

The University of Chicago

THE MENTALLY ILL AND PUBLIC
PROVISION FOR THEIR CARE
IN ILLINOIS

A DISSERTATION SUBMITTED TO THE FACULTY
OF THE SCHOOL OF SOCIAL SERVICE ADMINIS-
TRATION IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

1939

By
STUART KING JAFFARY

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EDITOR'S PREFACE

Illinois was one of the states on which Dorothea Dix cast her critical but constructive glance. In 1847, when she had already surveyed the conditions under which the insane were detained in Massachusetts (1843), in Delaware, Kentucky, New Jersey and Pennsylvania (1845), and in Indiana (1846), she made a similar comprehensive review of the needs of Illinois. The result was the establishment of the Institution at Jacksonville. The structure of the authority was that generally adopted in the states in which similar action had been taken--namely, a governing board of unpaid public spirited citizens appointed by the Governor who were responsible for the selection of the staff and for the general standards of administration. This form of organization lasted until 1910 when the Boards of Trustees of State Institutions were abolished and a State Board of Administration together with a Charities Commission took their place. These two authorities in turn gave way in 1917 to departmentalization and that form of organization is still in effect. The author summarizes this development in his first chapter and then devotes the rest of his discussion to the development of resources for care and treatment first in the state area and then in the local area. It is hoped that the study which has been made by a mature and experienced student of problems in this field may prove useful to public authorities, to those who are in immediate contact with the patients needing service and possibly treatment, and to those concerned for the development of public service on a sound and constructive basis.

Sophonisba P. Breckinridge.

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INTRODUCTION

The present study lies in the field of public responsibility for the care of the mentally ill. Taking the state of Illinois, it proposes to examine the extent to which "care of the insane" by the state authority has met the total need of services for the mentally ill. Actually, what responsibilities have been accepted by the state, and how effectively have these been discharged? What responsibilities remain with the local authority (the county), and in what manner have these been discharged? What relationships exist between these two authorities for meeting the total problem of care? As a resultant, is there evidence of unmet needs and what measures would appear to be appropriate for meeting them?

The State of Illinois was selected because of a combination of circumstances and reasons. The writer, a student of the Graduate School of Social Service Administration of the University of Chicago, was a resident of the state and had the materials of the study conveniently available. His interest in the care of the mentally ill dates from 1929, when for two years he was psychiatric social worker for the Provincial Mental Hospitals of the Province of Alberta, dealing with the social problems related to the care of the mentally diseased and defective, both intra- and extra-murally. His field work at the University of Chicago was done with the Social Service Department of the Chicago State Hospital, in the summer of 1932. Part of the summer of 1933 was spent in visiting other state hospitals, particularly Elgin and Kankakee, taking a special interest in the work of the social service departments. During these years attention was paid to the parole study in progress at the Chicago State Hospital ¹ and to the possibilities of family care of mental patients in Illinois. These interests brought contact with the Superintendent of Charities and the work of the Department as a whole. They also revealed that there was available only scattered information on the care of the mentally ill in Illinois for the recent period, and that such a compilation would therefore have utility.

¹See below, p. 128.

Beyond these circumstances lie other significant considerations. Illinois, in 1917, was the first state of the Union to departmentalize its governmental administration. It was also the first state in which the care of the insane became a responsibility of a state department of public welfare which was also charged with the care of other dependent groups. The question of the form of administrative unit best fitted for this purpose has received much attention in public welfare administration. The Illinois Department had an uncommon structural picture. New and interesting relationships were created between its officers--the Director, the Superintendent of Charities, and state Alienist, and others. An advisory Board of Public Welfare Commissioners added interest to the pattern. A study of the large responsibility of the care of the insane by such a department, then, should have inherent interest and value, both for the field of public welfare administration and for the state government in appraising its own efforts.

The period 1917-1937 is of interest in that it is one in which the new Department faced a variety of changing situations. It carried on its work under four different administrations: Governors Lowden (Republican), 1917-21; Small (Republican), 1921-29 (two terms); Emmerson (Republican), 1929-33; Horner (Democrat), 1933-41 (two terms). In the early period of its work the Department experienced the growing pains of its new structure--a structure that was tested severely by the economic and social disorganization of the war period. There followed eight years of economic calm and continuity of political control. The last decade has seen deep and widespread economic depression in the state and nation; a financial crisis in the state's administration, and the succession to power of the opposing political group. An examination of the fate of the mentally ill under a succession of such varied conditions itself should be informing.

In Illinois the factor of size adds directly to the importance of the study. The institutional care of the insane was already a large problem in 1917; it has increased steadily since that time. The state now operates nine large mental hospitals, ranging in size from 1,500 to 5,000 patients each, with additional clinical and research facilities. Patient population in these hospitals has grown from 17,360 in 1917 to 30,700 in 1938. Bien-

nial expenditures for their care have increased from \$6,812,000 in 1917-18 to \$14,469,000 in 1937-38. In the latter year the appropriations of \$14,469,000 constituted 40 per cent of the total expenditures of the Department of Public Welfare, exclusive of Old Age Assistance. The responsibility for the care of this number of mentally distressed persons, involving the wise expenditures of such large public funds, in itself constitutes a welfare problem of major proportions.

This growth of the mental hospitals during the period, together with the increased importance of the new developments in mental hygiene, properly raises the question whether or not a separate Department of Mental Health is now indicated in the state government. Added pertinence is given this question by other recent developments in the Department. There has been a large addition to its work by the advent of Old Age Assistance and further Social Security categories are to be expected. In another direction, the recommendations of the Schlarman Commission¹ for the separation of the penal institutions and services from the Department are important. In view of the present unbalanced administrative picture which the Department presents because of its un-directed growth, there is need for consideration of remaking the department structure. Attention is therefore paid to this basic problem.

From another approach the very magnitude of this necessary institutional provision suggests attention to the broader reaches of the problem. The outstanding characteristic of the past half century of custodial care by the states is that, despite the multiplication of large institutions, public mental hospitals have always been full to the doors; chronic overcrowding is a heavy shadow in the institutional picture. Why this ever expanding hospital population? The low recovery rate in mental disorders is usually put forward in answer; fewer patients are discharged than received, and institutional populations cumulate. But this very aggregation of patients should direct attention outward to the whole treatment process. This attention could be focussed at three points. What resources exist for the early treatment of the mental patient in the community, so that insti-

¹See below, p. 183.

tutionalization may be prevented? What resources exist within the state institutions for getting the patient out of the hospital when he is improved or recovered, and returned to his local community? Finally, are other kinds of extra-institutional care available, either for the institutional patient, or for the non-committed patient in need of some supervision?

These questions direct attention to the local community in which the patient lives, whose authorities commit him to the state hospital, and which receives him back (or does not) on improvement or recovery. There is more than a suggestion that the absence of local resources for treatment has accentuated the number of patients and the problem of care in the hospitals. The question of the measures taken by state and local communities to meet these broader needs therefore merits attention.

These reasons offer some justification for the study. Beyond these values, however, are certain broader considerations which may be served. Illinois is a mid-western state, not dissimilar to other states of the region and of the nation in governmental background and administrative developments. The experience of Illinois in the care of the mentally ill can be duplicated, with minor variations, in many other states. The problems presented are similar, and hence proposals made for Illinois have at least general application to conditions elsewhere, their application being varied by local conditions. The study should therefore make some contribution to the discussion of the national aspects of mental health administration.

Indeed, these national aspects of mental health administration are now moving into the foreground with the recent entry of the federal government into the mental health field. From the time of President Pierce's veto of Congress' grant of aid to the states for better care of the insane, in 1854, until the last decade, federal interest has been nonexistent. In the present decade, however, there have been increasing federal developments in this area, specifically through the United States Public Health Service. In 1929, Congress created a Narcotics Division in the Public Health Service to build and administer federal institutions for the care and treatment of drug addicts. The next year, 1930, the powers of this division were broadened, and its name changed to the "Division of Mental Hygiene." The operation of the insti-

tutions for narcotics continues as one of its main activities. Under the direction of Dr. Walter F. Treadway the division looked further afield. It worked out with the federal Bureau of Prisons a co-operative arrangement for physical and mental health services in the federal prisons on a merit basis, and continues to operate this service.

In 1935, Dr. Treadway presented a most significant paper to the American Public Health Association, entitled, "The Place of Mental Hygiene in a Federal Health Program."¹ The contents were as broad as the title suggests. The problem of mental health was acknowledged as one belonging to the public health field, and therefore one within the province of the U. S. Public Health Service. Specifically, he suggested that the Public Health Service should become interested in the question of standards of mental health administration across the country, the prevalence and needs of the mentally ill, consultant service to the states, and co-ordination of the present federal mental institutions.

A logical next step occurred in 1936, when plans for an evaluative survey of the state hospitals in the United States and Canada were made by several interested bodies, which sponsored the Mental Hospitals Survey Committee. Headed by Dr. Treadway, the Survey Committee had the backing and co-operation of: The U. S. Public Health Service, The National Committee for Mental Hygiene, The American Psychiatric Association, The American Medical Association, The American Board of Psychiatry and Neurology, The American Neurological Association, The Canadian National Committee for Mental Hygiene, The Canadian Medical Association. Funds for the operation of the Committee for a period of three years were obtained from the Rockefeller Foundation, and during the period 1936-39 all the mental hospitals in Canada and those in about half the states were studied. The Committee had a full-time executive staff of three persons, and the funds provided additional consultive staff as needed. It was the Committee's intention that this survey should have the result of setting minimum standards for mental hospitals, and that during its life and after its conclusion broad efforts should be applied to raise

¹U. S. Public Health Service, Public Health Reports, 51: 181-93. 1936.

the standards of those hospitals (and those states) which fell below the accepted minimums.

The consultive services offered by the Committee proved so helpful to several states that on the termination of the Rockefeller grant in 1939 the United States Public Health Service arranged to take over part of the Committee's staff and to continue its work as a federal health service. This provision of consultive service in the mental health field by the federal government marks the achievement of an important point in the program enunciated earlier by Dr. Treadway.

Of large importance, also, is the greatly increased activity of the Federal Government in the general field of public health. In November, 1934, Miss Josephine Roche was appointed an Assistant Secretary of the Treasury to study national health needs. In October, 1936, the Interdepartmental Committee to Co-ordinate Health and Welfare Activities was created by executive order, having as one of its duties, "to study and make recommendations concerning specific aspects of the health and welfare activities of the Government looking toward a more nearly complete co-ordination of the activities of the Government in these fields."¹

In 1938, the Interdepartmental Committee published a summary of the national health situation prepared by its Technical Committee.² This report set out in broad, clear strokes, the tremendous gaps in the nation's health services. Included was an appraisal of the national mental health situation which called particular attention to the overcrowding of existing state hospitals and to the great dearth of clinical facilities for extra-institutional treatment.

Following this statement of needs, the Interdepartmental Committee presented to the National Health Conference in July, 1938, a program³ for filling these needs. This program contained

¹Executive Order No. 7481. Franklin D. Roosevelt, October 27, 1936.

²Interdepartmental Committee to Co-ordinate Health and Welfare Activities, The Need for a National Health Program (Washington, 1938).

³Interdepartmental Committee to Co-ordinate Health and Welfare Activities, The National Health Conference (Washington, 1938).

further references to needs in the mental health field in the areas of institutionalization provision and clinical facilities. Federal grants-in-aid to the states for these purposes were recommended, to the total amount of \$211,500,000. Of this amount, \$201,500,000 was designated for hospital construction and operation, and \$10,000,000 for increased clinical facilities.

These recommendations were embodied in the Wagner Health Bill of 1939.¹ Section 601 of the Bill included mental health among the purposes for which grants are to be made to the states for improving public health work; \$15,000,000 was designated for this purpose for the years 1939-40, and increasing sums thereafter. Section 1201 makes provision for grants to the states for the erection and operation of hospitals, including mental hospitals. The U. S. Public Health Service is named the federal administrative agency for both these grants.

The entrance of the U. S. Public Health Service as an active agency into the field of mental health administration is of particular significance at this time, when the powers of the federal government in welfare matters are being so greatly widened. This federal interest, too, marks the beginning of a new period, wherein some degree of federal authority is established in the field of mental health administration. Such a development, following a half century of state care, opens a new vista for mental health administration in the United States.

The development of such a federal authority, however, has substantial precedents, both American and European. In the evolution of public welfare services in the United States examples are not lacking of the transition of a federal agency, originally of research and advisory nature, to one with larger administrative powers; the U. S. Children's Bureau is a familiar example. Again, European practice shows examples of central authorities in this field, having supervisory or administrative powers; the English and Scottish Boards of Control are illustrations in point, as is the Mental Health Department of the U.S.S.R. Evidence is not wanting of European influences in recent American welfare legis-

¹"A Bill to provide for the general welfare by enabling the several states to make more adequate provision for public health" etc. (February 28, 1939), Senate Bill 1620, U. S. Seventy-sixth Congress, 1st Session.

lation and practices; to this desirable procedure of studying foreign experiences and adapting appropriate phases to American needs the field of mental health administration should be no exception. Much of advantage can be learned in other jurisdictions, particularly in the social work fields of after-care and family care of mental patients.

There is a close relationship, too, with health insurance. Mental health administration is already a predominant phase of existing public health activity through state operation of the mental health services. Its acknowledgment by the federal government assures its incorporation in any scheme of national health services or insurance. Such an integration is certainly to be desired, but contains tremendous problems of social administration. The working out of these vital problems will be the task of the social administrator for the next several decades.

The material for the study has been drawn largely from official sources--the statutes creating the Department and governing its work; its annual reports and other publications; departmental records of finance and personnel; numerous interviews with the Directors, Superintendent of Charities, Alienists, Chief of Social Service, Secretaries of the Board of Public Welfare Commissioners, Managing Officers and Assistant Managing Officers of the hospitals, social service workers, and others, during the period 1932-38.

In addition to the hospital visits, two periods were spent in the general office of the Department at Springfield, in 1937 and 1938, to consult records and gather information not available elsewhere.

As source material, the official reports and publications of the Department had marked limitations. At times they were voluminous but uninforming; at other times nonexistent. As its publications are the official record of its work some comment on them is of interest at this point.

The Department publishes material of three kinds--the Annual Report, the Report of the Statistician, and the Welfare Bulletins. The Annual Report has appeared regularly since 1918, with the exception of the years 1932 through 1935, which four-year period was covered by a single report. The report of the Statistician first appeared for the fiscal year 1921-22, as part

of the Annual Report, and was published as a separate annual report from 1924 through 1930. Since 1930, it has appeared biennially.

The present Welfare Bulletin is the third form of departmental bulletin during the period. It was preceded by the Institution Quarterly, established by the Board of Administration in 1909, and edited in turn by Frederick H. Wines and A. L. Bowen; the Quarterly continued through 1925. During the second Small Administration, from September, 1926, through February, 1929, the Quarterly was replaced by the Welfare Magazine, a monthly publication of more pretentious form. The Welfare Magazine, however, was abandoned under the succeeding Emmerson administration, to be replaced by the present Welfare Bulletin in February, 1930, after a gap of a year.

The content of both the Annual Report and the various bulletins varies widely. The Report usually contains the reports of the Director and other executive heads, the Alienist and Criminologist, other technical advisors, the managing officers of the various institutions and heads of services, and the Board of Public Welfare Commissioners. All of this content is usually present but parts of it may be lacking for one or several years without explanation or later summary. Additionally, some volumes of the Annual Report include the Report of Statistician, some do not. The contents of the various bulletins range from simple "human interest" stories through reports of meetings and conferences to the annual reports of the Director or other officials. Not uncommonly these varied items will all be found on the same page.

The content of the constituent reports within the Annual Report shows wide variation. The Director's report varies from a few curt sentences in a letter of transmittal to pages of departmental detail. The content of successive reports is rarely uniform or even similar. The same comment is applicable to the reports of the division heads and the Alienist. No uniform content for the reports of the managing officers was adopted until 1936, so that the reports of individual hospitals also vary greatly, depending on the personality and interests of the managing officer. Some are merely statistical tables of public works or agricultural production, with little or no information about the patients, the institution, or its conduct. Others are more

informing, but lack consistency from year to year. As a result it is difficult to get either an adequate picture of all the hospitals at any one time, or of the same hospital over a period of time.¹

There is also difficulty in getting a clear account of the Department's work from the content of the reports. The reports of the Director and Superintendent of Charities often lack organization; they are confused and incomplete; inconsequential material is often repeated in different forms, while basic information is lacking. This confusion is increased by repetition of the same material in the several reports of the Alienist, Superintendent of Charities, and Director. It is worsened by the reproduction in the report of addresses which officials have made throughout the year, so that the reader is at a loss to know, from the mass of material presented, which points are significant. Finally, he is puzzled by the kind of "economy" which attempts to cover the Department's activities in the four important years of 1932-35 in a single abbreviated volume, to be followed by subsequent years of expansive volumes with pages of such trifling details as the forms for condemning materials and male and female laundry lists.²

Finally, there is a good deal of duplication between the different publications of the Department. For several years, the report of the statistician is included in the report of the Department, and also published separately. Articles and addresses are frequently printed in both the Institution Quarterly or the Welfare Bulletin and the Annual Report. Conversely annual reports of officials also appear in the Institution Quarterly or in

¹Because of the incomplete content of the printed reports, an effort was made to locate the original (typewritten) reports submitted by the managing officers to the Director. The Department, however, kept no central file of these reports; after editing them for the departmental report they were discarded. Copies at the hospitals proved to be fragmentary; no hospital had a complete file of its own reports, 4 had incomplete files, and 4 had only the reports as printed. Several reported the destruction of reports and documents by preceding administrations on relinquishing office.

²In the use of Illinois reports there is always present the sharp contrast of their rambling content with the well prepared documents of the New York and Massachusetts departments.

the Welfare Bulletin. This failure to restrict types of material to their appropriate medium is both wasteful and confusing.

In contrast to the deficiencies of the Annual Report, the Report of the Statistician is both consistent and informing. Based on the standard reporting system worked out in 1920 by the Bureau of the Census and the National Committee for Mental Hygiene, its content remains uniform and useful, making possible quantitative comparisons in several directions. Because of this conformity to the nationally accepted framework, comparisons with other states or national data are also facilitated. While the utility of this report is enhanced by the absence of consistent material elsewhere, the Department deserves credit for its continued compilation and publication throughout the period.

The present study has some necessary limitations in scope. It is directed primarily at the large central problem of the non-criminal insane. The criminal insane present a particular problem, and their care has already been described elsewhere.¹ It also excludes the feeble-minded, as this group has also been previously studied.² The feeble-minded, too, present primarily a problem of training rather than therapy.³ These related groups, then, have been omitted, and attention directed towards the work of the large state hospitals and the related services.

¹Mary Harms, "The Care of the Criminal Insane in Illinois" (Unpublished Master's thesis, University of Chicago, 1927).

²Elizabeth C. Davis, "State Institutional Care of the Feeble-minded in Illinois" (Unpublished Master's thesis, University of Chicago, 1926).

Savilla Millis, "A Study of the Admissions to the Juvenile Detention Home of Cook County" (Master's thesis, University of Chicago, 1927).

³In Illinois administration, the institutions for the feeble-minded at Dixon and Lincoln were a responsibility of the Alienist under the Lowden and first Small administrations (see below, p. 22). After that time they appear to have been adrift in the Department, without regular professional supervision. They occasionally asked help from the Criminologist, with whom they had relationship through the Institute for Juvenile Research. The Institute supplied the psychological service to the Juvenile Court of Cook County, and hence compiled case histories on many of the committed children. The losses suffered by these two institutions during this period of orphanhood are noted by the Chicago Institute of Medicine, in its later study (see below, p. 77).

Acknowledgment is gratefully made to Mr. A. L. Bowen, Director of the Department, for permission to make the study, and to him and to all those officials and others who gave of their time and effort in supplying information and materials for the study. Their interest and ready co-operation has made the study possible. If it contributes in any degree to the promotion of more humane and decent standards of care for that large, unfortunate group, the distressed of mind, whether within or beyond the borders of Illinois, the effort will have been justified.

PART I

THE STATE AUTHORITY

CHAPTER I

THE DEVELOPMENT PRIOR TO 1917

The care of the mentally ill is one of the oldest of social problems. Through the centuries there has been an evolution of care by changing authorities--the church, the local community, the state, the central authority. Policies affecting their care have been successively influenced by the points of view of religion, of custody, and, in our own day, of therapy and rehabilitation. The present study is an examination of their care in a recent period by an American state government. A useful orientation to it, however, will be afforded by a glance at this historic background.

In medieval times the belief in demon possession as the cause of insanity was general. Hence the insane were feared and shunned, and "treatment" was directed toward removal of the evil spirits. Witchcraft, with its incantations and potions, was often used to this end. But more usual were religious rites of various kinds; the evil spirit was to be exercised by religious rituals or commands, often mixed with dippings or floggings. Certain wells acquired reputations as being beneficial, and around them shrines tended to grow up, to which patients and their guardians flocked in hope of cure. Certain saints or places likewise acquired reputations, the famed colony of Gheel, in Belgium, having its beginnings in this way, built around the shrine of St. Dymphna. At these or other places, chronic insane tended to accumulate and refuges were erected for their care. From such a beginning grew the well known Bethlehem Hospital in London.¹

Religious treatment waned with the abandonment of demoniacal theory, to be gradually replaced by the embryo science of medicine. Mental disorder was now laid to good or bad "humors," and appropriate treatments were applied. In the earlier period

¹An interesting account of this earlier period is available in Albert Deutsch, The Mentally Ill in America (New York: Doubleday, Doran & Co., 1937).

various "potions" were favored, doubtless influenced by the magical treatments of the earlier age; the prescriptions acquired a more scientific dress as medical knowledge increased. Bloodletting, a broad treatment for many diseases, was widely used for mental disturbances. But little medical knowledge of value appeared until the present century.

In the community, the mentally disordered person was looked on with increasing suspicion and fear. His behavior was unusual and unexplained, perhaps a danger to himself or others. The seventeenth and eighteenth centuries saw the growth of the English towns and the rise of local government. Life in the towns was more complex than in the rural areas, and the care of the disordered person was therefore more of a burden to his family. In towns, too, his behavior was observed by and affected more people; if dangerous, he was able to do more harm to others. Hence more social pressure was brought on his family or on public officials for his incarceration.

Moreover, he was unfitted for work and so was idle. The expanding powers and duties of the local authorities brought the disordered person under their jurisdiction on both counts. His disposition was often the same on either count--he became an inmate of the local workhouse, or if resistant or violent, was placed in the stronger confines of the local jail. At this initial stage of public responsibility, then, the local authority was responsible for the whole process of apprehension, commitment, custody, and release of the disordered person.

In the workhouse accumulated the destitute and distressed of all kinds--able-bodied and impotent, well and sick, the homeless and vagrant, the mentally deficient and mentally disordered--a motley and pitiful group. Originally, each parish in England was obliged to erect such a workhouse, though later neighboring authorities could unite for this purpose. There was also a growth of private asylums--the "madhouses" of the time--which offered care for disordered persons at appropriate fees--and few questions asked.

The wretched conditions of existence in the mixed workhouses and the unspeakable conditions of filth, cruelty, and neglect surrounding the mentally ill in jails and madhouses was enough to offend even the coarse sensibilities of eighteenth

century England. An additional spark was supplied by the abuses of admission to the private madhouses, many of which came to be convenient repositories for inconvenient spouses or relatives. The growing humanitarianism expressed itself in a movement of reform, usually dated from 1795, when Pinel made his historic gesture of striking the chains from the limbs of insane patients in the Bicêtre of Paris.

Active in the English movement was the distinguished Quaker, William Tuke, director of the York Retreat and strong advocate of non-restraint. He was ably succeeded by two generations of his children, Samuel Tuke and Daniel Hack Tuke. In public circles the work of Lord Shaftsbury was outstanding. Anthony Ashley Cooper (later Lord Shaftsbury) was a leader of parliamentary committees investigating abuses in public and private asylums, and throughout his lifetime a zealous worker for higher standards of care. His experience in dealing with the many small local workhouses and asylums demonstrated that with the limited means of the local authorities, only low standards of care could result. He therefore worked toward the union of neighboring local authorities for the erection of proper asylums which would allow decent standards of care. Together with this improved local provision, however, he was a firm advocate of a strong central authority responsible for the establishment of national minimum standards and their enforcement through supervision. For much of his lifetime he was the chairman of that Authority, the Board of Control for England.

In America, the incarceration of the mentally disordered in almshouses, jails, and prisons prevailed well through the nineteenth century. The beginnings of state care, however, were evident even in the Colonial period. In 1751, the provincial legislature of Pennsylvania appropriated funds for the Pennsylvania Hospital in Philadelphia; it was the first state-aided hospital in America to provide medical care for mental patients. Virginia, in 1769, erected at state expense the Lunatic Hospital at Williamsburg, an institution exclusively for the insane, wherein indigent patients were cared for by the state. A half century later, in 1822, the East Kentucky Lunatic Asylum at Lexington was established, providing state care for indigent patients of that state.

The first part of the nineteenth century found a few states

building state institutions for the mentally ill. However, this move toward state responsibility was hesitant and gradual; partial responsibility only was accepted. The few state institutions which were built generally provided for care at local expense, and charged the towns or counties for each local resident cared for. Private patients were also cared for at the expense of their families. Because of the charges, relatively few patients were admitted, the greater number remaining in their homes, or in the wretched confines of local almshouses or jails. Of those admitted, however, an increasing number of "state patients" accumulated, whose local residence was unknown or in dispute, and for whom the state assumed the responsibility of institutional care.

The amazing crusade of Dorothea Dix in the 1840's and 1850's awakened the local and state authorities to the misery of the insane, and resulted in a rapid extension of state responsibility, expressed in the many new state institutions for their care. At the same time the earlier hope of "curing the insane" was fading, and states had to face the need for more ample provision for custodial, long-time care. These influences resulted in increased state activity in the latter part of the century, so that by the end of it every state had made some provision for the custodial care of its mentally disordered, and the larger states each had a number of institutions. To these new institutions flowed the insane from almshouses, jails, and prisons, together with an increasing number from the care of families or friends. This general assumption of custodial care by the state, and the transfer to its responsibility of the thousands of patients formerly under local care or no care at all, was the outstanding development of the nineteenth century in making better public provision for the mentally ill.

The direction of these institutions was originally under local boards of trustees; these local boards usually had only a vaguely defined responsibility to the governor or legislature. With the geographic and social isolation of the "asylums," it is not surprising that abuses tended to develop and standards of administration remained low. These factors, coupled with the mounting costs of operation, brought the whole institutional problem to the attention of state legislators in the period after the Civil War. The first attempt at state co-ordination was made by

Massachusetts, when after investigation and recommendation by a legislative committee the first Board of State Charities was established in 1863. The Board was given supervisory power over the whole system of public charities within the state, including the three mental hospitals. The movement for supervision spread rapidly, ten additional states establishing boards of similar purpose within the next decade; other states followed later.

These state boards were everywhere faced with overcrowded institutions; new buildings became overcrowded as soon as opened. Thus began the long period of chronic overcrowding of the state mental hospitals which has marked their course to the present time.

With the growing number and expense of these larger institutions the problems of administration and control assumed increased importance. The state boards soon found that supervisory powers were not enough; actual power of control and co-ordination were needed to effect positive results. Hence in many states their powers were broadened to include administration and control of all state institutions. In some of the larger states, separate boards of administration were created for the insane, for correctional institutions, and for the charitable ones. The most recent step has been that of departmentalization of state governments, following the "economy and efficiency" movement in the first three decades of this century. In these reorganizations, the welfare functions of the state were frequently grouped in a Department of Public Welfare (or of similar name). Some larger states, again, created separate departments for mental health, corrections, and other social services. By 1937, state services for the custodial care of the mentally ill were integrated into some such central board or department in twenty-four states.

The twentieth century also brought new vistas of knowledge to the understanding of human behavior. The tragic experiences of Clifford Beers in America brought about the organization of the mental hygiene movement, dedicated to spreading the concept of mental illness, and of substituting understanding and therapy for the discipline and custody of the then-prevailing institutions. Medical and psychiatric advances favored the movement, illuminating vast new reaches of human behavior. In the light of this newer knowledge the old problem of "insanity" became only one

phase of the much broader problem of mental illness. Causation, formerly a sudden and inexplicable process, was now seen to be rooted in the whole life cycle of the individual, and related directly to his environment. To this new orientation, also, were added specific advances in medicine which offered effective therapies for an increasing number of mental disorders.

The present century has seen advances, too, in the science of public welfare administration. New principles of administration have developed from the social sciences. As these principles have been formulated and applied, more adequate machinery and procedures have been evolved in all areas of welfare administration. One of the largest of these areas is the public responsibility for the care of dependent groups--the dependent child, the offender, and the mentally ill. The care of the mentally ill has become a responsibility of state and local governments. To what extent these modern principles of welfare administration have been applied to meet this very old problem should therefore be an inquiry of interest and profit.

The history of the care of the insane in the state of Illinois illustrates most of the general developments sketched in the earlier pages.¹ The first state hospital for the insane was established at Jacksonville in 1847. Twenty years later the problems of the several charitable institutions, and the need for others, were challenging enough to call for some central supervision, and in 1869 the legislature created the Board of State Commissioners for Public Charities for that purpose. At the same time two new hospitals for the insane were established, one for the northern part of the state at Elgin, and for the southern part at Anna.

The Board of Charities (as it is usually called) functioned from 1869 until 1909. These forty years saw large changes in the state. Its population increased from 2,540,000 in 1870 to

¹For much of this material the writer is indebted to two earlier studies: William Willard Burke, "The Supervision of the Care of the Mentally Diseased by the Illinois State Board of Charities (1869-1909)" (Unpublished Ph.D. thesis, University of Chicago, 1934); Coyle Ellis Moore, "The Cost of Administration of Public Welfare in Illinois, 1904-1925" (Unpublished Ph.D. thesis, University of Chicago, 1928).

5,639,000 in 1910. The great metropolitan area in and around Chicago took shape. Additional hospitals were built, at Kankakee in 1877, for insane criminals at Chester in 1889, at Watertown (later East Moline) and Peoria in 1895. Beginning with one hospital with some 400 patients in 1869, the Board's responsibilities (for the insane only) had grown to cover seven large hospitals with a population of more than 10,000 patients.

This influx of patients came from two sources: the increasing population, and the transfer of insane patients from local almshouses and jails to the state hospitals. This growth of state care was one of the chief achievements of the Board of Charities. Charged originally with the inspection of county almshouses and jails, it found the lot of the insane confined there to be so harsh and cruel that care by the state in proper state institutions was the only alternative. This transfer, however, was not achieved until the last decade of the Board's life; as Moore points out:

During the twelve year period from 1894 to 1904 approximately 25% of the public insane were in the county almshouses. The opening of the Watertown State Hospital in 1898 was the beginning of a determined movement to empty the almshouses of the insane. The Peoria State Hospital was opened in 1902 and immediately the insane population of the county almshouses began to diminish.¹ On June 30, 1909, only 121 insane remained in the almshouses.

The single large exception to state care was the Cook County Asylum, administered by the Board of County Commissioners, which, in 1909, cared for some two thousand patients.

The work of the Board of Charities has been exhaustively covered by Burke² and can be briefly summarized here. For the insane, its major task was the development of state care, and the transfer of patients from the jails and almshouses to the new state hospitals. Related to this task, however, was the supervision of plans for the new hospitals themselves. In this area the work of the Board was distinguished at one point--the advocacy of "the cottage plan" for large public institutions. Largely for reasons of tradition and economy in construction, public institutions everywhere had been built of the "congregate" type--large,

¹ Moore, op. cit., p. 35. ² Burke, op. cit.

solid blocks of masonry, in a single barracks-like building, after what was known as the Kirkbride plan, perhaps housing several thousand inmates in a single such block. The Illinois Board rejected the congregate plan, largely on the stimulus of its secretary, Frederick H. Wines, who was an earnest and active advocate of the cottage plan.

The Illinois Eastern Hospital for the Insane, established at Kankakee in 1877, was the first cottage plan hospital to be built in the United States, and as such attracted international attention. Its advocates pointed out that its appearance, a group of buildings about a central campus, minimized the depressing appearance of the congregate institution, allowed for classification of patients into small and appropriate groups, and permitted easy modifications or additions. These and other factors made for improved environment and better therapy. Unfortunately, the legislative appropriations for the two hospitals erected in 1895 were too small to allow cottage construction, and semi-congregate institutions resulted. The cottage plan; however, was later strongly revived under the Department, and continues as a sound principle of institutional practice at the present time.

No summary of this period is complete without further reference to the work of Frederick Howard Wines, Secretary to the Board of Charities during most of its existence. Son of Dr. E.C. Wines, minister and distinguished penologist, Frederick Wines likewise trained for the ministry, but moved from it into an active role in the emerging field of public welfare administration. In addition to his outstanding service to the State of Illinois, he was a national figure in welfare work, having an active part in the organization of the National Conference of Charities and Corrections (later the National Conference of Social Work) and the American Prison Association. He also acted as Assistant Director of the Bureau of the Census from 1899 to 1902.

Working with Mr. Wines in his later years of service was another important and influential group, "The Deneen Board of Charities." Until 1892, the state institutions had enjoyed reasonably good standards of administration, with security of tenure and freedom from political interference. The following three administrations, however (Governors Altgeld, Tanner, and Yates), were marked by a regression to spoils politics which blighted

institutional staffs and morale, undoing much excellent work which had preceded them. A change for the better came with the administration of Governor Deneen in 1905; in his two terms he did much to restore the welfare services to their former standards.

His instrument for this purpose was "The Deneen Board of Charities"--a strong and effective Board which held office under this name from 1906 to 1909. Several of its members continued on the succeeding State Charities Commission for a second period of four years. The Board was headed by Dr. Frank Billings, of Chicago, and had as its other members Mrs. Clara Bourland of Peoria, Rabbi Emil G. Hirsch of Chicago, Miss Julia C. Lathrop of Rockford, and Dr. John T. McAnally of Carbondale; Dr. Billings, Rabbi Hirsch, and Dr. McAnally continued as members of the State Charities Commission. The exceptional quality of the personnel of these Boards was a guarantee of the Governor's statement on their appointment: "I have appointed a new State Board of Charities to infuse a new spirit into the administration of the State charitable institutions."

The Deneen Board of Charities "infused a new spirit" by several marked steps forward. A Civil Service law had become effective in 1905, and the Board worked closely with the Civil Service Commission in establishing qualifications for institutional and other positions, and in their application. This application of merit selection to all positions below that of superintendent resulted in a large improvement in the quality of institutional staff. Training schools were also established for nurses and attendants. These two steps promoted morale and efficiency in the whole institutional service. Treatment facilities were also improved by the addition of separate reception buildings in several hospitals, to permit more thorough examination and active treatment of new patients. These new facilities, manned by competent staff, greatly strengthened the therapeutic resources of the hospitals.

The Board, moreover, was active in a larger sphere--that of creating a new agency of administration for the state welfare services. The Board of Charities, as noted earlier, was a supervisory body only, and lacked administrative power, to carry out its recommendations. As the state's welfare responsibilities increased in size, the lack of administrative authority became more

of a handicap to its work. The defect was noted early in its life, and even in 1873, four years after its inception, there was some feeling in the legislature for a Board of Control.¹ In 1883 a bill calling for the consolidation of all state charitable institutions under one board was defeated. In 1897, Governor Tanner, in his inaugural address, recommended the abolition of all local boards of state institutions, substituting therefor two state administrative boards, each of three members, one for mental hospitals, the other for all other state institutions. A bill incorporating this change was introduced, but failed to pass in the Senate. The succeeding governors, Yates and Deneen, favored measures for a board of control.

The form of such an administrative authority was made a subject for special study by the Deneen Board of Charities. In 1908, it recommended a salaried Board of Control of three members, and an unpaid Board of Inspectors of seven members. After some legislative jockeying a bill embodying these provisions passed both houses, and became effective on January 1, 1910. The members of the new Board of Administration were promptly named, and the Board, in preparation for its new duties, visited all the Illinois institutions, as well as those in other states; particular attention was paid to the New York State Commission of Lunacy. Frederick H. Wines was appointed statistician to the new Board and proceeded to organize a competent clerical force.

The Board of Administration was given full administrative powers over the state charitable institutions, and their local boards were abolished. To continue the inspectional and advisory functions of the former Board of Charities, there was created the State Charities Commission, an unpaid board of five members. On this board, as noted above, Dr. Billings, Rabbi Hirsch, and Dr. McAnally continued to serve, forming a valuable advisory group to the new Board of Administration.

The work of the Board of Administration and the State Charities Commission is well described by Moore² and can be briefly summarized here. The life of the new administration was

¹See Moore, op. cit., chap. iii, "The Movement for a Board of Control."

²Ibid., chaps. iv, v, and vi.

short, lasting only until July, 1917, when the state government was reorganized under a departmental plan. These eight years, however, saw good administration by the new Board. The centralization of the administrative process resulted in economies without sacrifice of standards. The advances made under the Deneen Board of Charities were consolidated during Governor Deneen's second term, 1909-1913; the application of civil service was broadened and strengthened; standards of care were maintained and improved methods of therapy applied.

In its administration of the mental hospitals the Board had valuable assistance from several sources. As its statistician, Frederick Wines brought to it a wealth of experience and a humane, progressive philosophy. Technical advice was available from the alienist member of the Board, an office filled successively by Dr. J. L. Greene, Managing Officer of the Kankakee State Hospital, Dr. Frank P. Norbury, also of Kankakee, and Dr. George A. Zeller of the Peoria State Hospital. These men were all competent psychiatrists and proved administrators. And, on matters of planning and policy, Dr. Billings and his Commission provided suggestions and aid.

The chief expansion in plant during the period occurred in the transfer of the Cook County Asylum to the state in 1912. This institution, located at Dunning, on the northwest edge of Chicago, had some 2,000 patients at the time of transfer. In the state hospital system it has always been a strategic unit because of its metropolitan location, and proximity to both Cook County Psychopathic Hospital and the various medical schools and clinics. With its transfer was ended the last large unit of county care of the insane. Cook County, however, continued to care for some insane persons, mostly senile cases, in the old Cook County Almshouse in Chicago and later at the new Oak Forest Institution at Oak Forest.

In state governmental circles, another administrative change was taking form. During the administration of Governor Dunne, 1913-1917, the movement for "economy and efficiency" in state government gained headway; studies of reorganization of the state services were made by several legislative committees. The various welfare functions, involving large expenditures and personnel, naturally were brought under scrutiny. Governor Lowden,

succeeding Governor Dunne in 1917, had been elected on a platform of reorganization of the state government, and submitted his plan of reorganization to the state legislature early in 1917. Its essential features were approved in the bill creating the Illinois Civil Code, effective July 1, 1917. The Act called for a major reorganization of most branches of the state government, consolidating hitherto separate boards, bureaus and commissions into major code departments, each under a Director who was to be a member of the Governor's cabinet.

The Department of Public Welfare was one of the largest created by the Code, in terms of its expenditures, number of employees and wide responsibility for the wards of the state in state institutions. The correctional institutions and services, originally under the Board of Charities, but never a responsibility of the Board of Administration, were included in the Department, which had as its three main functions the care of the insane, the correctional institutions and services, and a miscellaneous group of institutions and services relating to child welfare and the physically handicapped.

By 1917, the care of the insane had come to be a responsibility of considerable size. The new Department took over from the Board of Administration the care of some 18,000 patients, in 8 large institutions varying in size from 700 to 3,500 patients each. These hospitals were staffed by some 2,000 employees, and the expenditure to provide care for this large number of patients was \$6,812,000 for the biennium 1917-19. It can be seen, therefore, that this one phase of the Department's work was itself a large responsibility at the outset. How well it was discharged is the subject of examination in the following chapters.

CHAPTER II

THE DEPARTMENT OF PUBLIC WELFARE

The Department of Public Welfare was one of the nine original code departments created by the Civil Administrative Code of 1917.¹ These departments were: The Department of Finance, The Department of Agriculture, The Department of Labor, The Department of Mines and Minerals, The Department of Public Works and Buildings, The Department of Public Welfare, The Department of Public Health, The Department of Trade and Commerce, and The Department of Registration and Education. Additional departments, created in 1925, were: The Department of Purchases and Construction, and The Department of Conservation.

Each department had as its head a Director, appointed by the Governor with the consent of the Senate. The Director, as chief executive officer of the department, was empowered to prescribe the necessary regulations for its proper functioning. He was required to furnish the Governor an annual report of the work of his department before December 1st of each year.

For the Department of Public Welfare, other code officers were named, as follows: The Assistant Director of Public Welfare, The Alienist, The Criminologist, The Fiscal Supervisor, The Superintendent of Charities, The Superintendent of Prisons, and The Superintendent of Pardons and Paroles. With the exception of the Directors, the powers and duties of the other officers were not defined by the Code. They were responsible to the Director, who, in turn, was given full power to define their duties.

The Department of Public Welfare was empowered to take over the work of the Board of Administration relative to the state charitable institutions. These included the hospitals for

¹The following account of the departmental structure is taken from the Code: "An Act in Relation to the Civil Administration of the State Government, and to Repeal Certain Acts Therein Named, March 7, 1917," Laws of the State of Illinois, 1917, pp. 4-28.

the insane, and the institutions for children and for the physically handicapped.¹

The Department was given an advisory board, the Board of Public Welfare Commissioners, with inspectional and advisory powers, to continue the work of the former State Charities Commission. The new Board was to have five members, appointed by the Governor, and responsible to him. Its duties were the investigation of the condition and conduct of the charitable and correctional institutions of the state; the conduct of special investigations into particular phases of institutional administration at the request of the Governor; the inspection of all private institutions and agencies coming under the supervision of the Department; and the collection and publication of statistics of insanity and crime.²

The Code departments most closely related to the Department of Public Welfare are those of Finance, Public Works and Buildings, Purchases and Construction, and Agriculture. The Department of Finance has power to prescribe uniform systems of accounting and reporting in all other departments; to examine their accounts and expenditures, and to prescribe rules governing the purchasing of supplies. It is also in charge of the budgetary procedure for all departments, and has the responsibility of coordination of the work of the several departments in the interests of efficiency and economy.

The Department of Public Works and Buildings was originally in charge of construction of new public works and buildings for the several departments. This function was transferred in 1925 to the newly created Department of Purchases and Construction. The Department of Agriculture serves as a consultant to

¹The Department also took over the powers and duties of: The State Deportation Agent, The State Agent for Visitation of Children, The Illinois State Penitentiary at Joliet, The Southern Illinois Penitentiary at Menard, The Illinois State Reformatory at Pontiac, The Board of Prison Industries, and The Board of Pardons. The penal institutions and the work of the Board of Prison Industries came under the jurisdiction of the new Superintendent of Prisons; the Board of Pardons under the new Superintendent of Pardons and Paroles.

²Civil Administrative Code, sec. 54.

other departments which have use for its services, and particularly the Department of Public Welfare with its numerous institutions and their connected farms and farm problems.

The Financial Structure

Finances are the life blood of any operating department; their importance to the Department of Public Welfare is to be measured in terms of the quality of care of human beings--citizens of the state who are temporarily or permanently its wards. Under the Code organization the Department of Finance was given large powers over the financial procedures in the Code departments. These powers relate chiefly to budgeting, expenditures of the regular biennial appropriations, and supervision of capital or emergency expenditures.

The budgetary procedure, as set out by the Code, set up a process, which, emanating from the Director of Finance, spread down into the state departments and then into their divisions. The many divisional budgets so made were then assembled by departments and integrated into the state budget.

The details of this procedure were clearly set out in the Code.¹ The Director of Finance was charged with the distribution of suitable budgetary forms to all branches of the state government, by the fifteenth day of September preceding the biennial meetings of the General Assembly. He could request such information on past and current expenditure and needs as was useful to the purpose. The information was to be returned to the Director of Finance by November first, together with relevant explanations. The Director of Finance, after securing such additional information as he might need then had the responsibility of revising and consolidating the departmental budgets into the state budget for presentation to the Governor. The Governor, in turn, was required to submit the state budget to the legislature, not later than four weeks after its organization.

In practice, the budgetary forms for the divisions and institutions of the Department of Public Welfare are transmitted through the department, from the Fiscal Supervisor to the several institutions, together with any comment the Director may wish to

¹Ibid., sec. 37.

make relative to state or departmental policies affecting the coming biennium. On completion by the managing officers of the institutions they are returned to the Fiscal Supervisor, and are consolidated by him into a tentative departmental budget. This is reviewed by the Director and the Fiscal Supervisor. The managing officer of each institution is then called in for conference with these two officials, to explain, discuss, or defend the amount requested. Out of this series of conferences the departmental budget is shaped, and transmitted to the Director of Finance, as called for by the Code. Here, a similar review process is repeated, with the directors of departments appearing on behalf of their respective budgets. In extreme cases, irreconcilable differences between a director and the Director of Finance are appealed to the Governor for opinion or decision. On approval by the Director of Finance, the state budget is then transmitted to the Governor for his consideration, and ultimately for presentation to the Legislature.

Once the appropriations have been made by the Legislature the reverse process occurs. The Director of Finance, annually, in advance of the fiscal year, transmits to each department director notification of the amounts appropriated for its use. The Fiscal Supervisor, with the approval of the Director, then similarly notifies each institution managing officer of the amounts at his disposal for the period.

The appropriations are made in a specified form, set out by statute,¹ covering the main items of expenditure, as follows:

- 1) Salaries and wages
- 2) Office expenses
- 3) Travel
- 4) Operation
- 5) Working capital
- 6) Repairs
- 7) Equipment
- 8) Permanent improvements
- 9) Land
- 10) Contingencies
- 11) Reserve

Total

¹Laws of the State of Illinois, 1919, sec. 13, "An Act in Relation to State Finance."

These itemized appropriations are inflexible in that a managing officer has no power to overexpend his appropriation for a given item, or to shift expenditures from one item to another, without the approval of the Fiscal Supervisor and the Director. For ordinary situations this approval is not difficult to obtain, though a large overexpenditure or the nonexpenditure of an appropriated amount would be subject to question and review.

Transfers of amounts between institutions or divisions lie at the discretion of the Director, subject to the approval of the Director of Finance. The Director, therefore, has leeway within his departmental appropriations to transfer surpluses to meet shortages that may develop. Anticipated expenditures beyond the appropriated amounts may call for a transfer of funds between departments, a power which rests with the Director of Finance, or for meeting from the Governor's Contingency Fund, at his discretion. Beyond these resources, supplementary appropriations only are possible, as occurred during the period of the state's financial difficulties of 1931-35.

As a device for administrative control, the Fiscal Supervisor transmits quarterly to each managing officer a statement showing his actual expenditures to date, compared with his annual appropriation pro-rated on a quarterly basis. This enables the department and the managing officer to note his rate of expenditure and his unexpended balances for each item. Any marked deviations may call for an explanation to the Fiscal Supervisor. By this device, tendencies toward unexplained or unbalanced expenditures are noted and can be corrected while still small in amount.

The supervision of capital or emergency expenditures follows the same procedures. All vouchers for payment against such appropriations are checked by the Department of Finance. Payments for construction under the supervision of the Department of Purchases and Construction must bear the approval of that department, certifying to the receipt of the goods purchased or the quality of work done.

The Department of Finance, therefore, is given large powers of financial review and control over the other Code departments, including the Department of Public Welfare. Though this power is large, it appears to have been so exercised during the period under review that no instances of serious friction between

the two departments have been noted. The procedures for budgetary and financial control, as provided for by the Code, have served to promote sound financial and administrative control over state expenditures.

The Lowden Administration

The reorganized state government was a craft launched on a troubled sea. Due care may have been taken in its building, but none could have foreseen that its first trial would be in waters made turbulent by the nation at war. Three months before the new government took office, the nation had gone on a war footing and by July 1, 1917, national planning and activity was geared to the new status. Amidst this changed and difficult situation the new government had to make its way. And make its way as a pioneer, also, as it was the first state to undergo such radical reorganization of its governmental structure; no guideposts of experience marked the way. Large credit must be given to Governor Lowden and his cabinet of Directors for the able conduct of the new administrative machinery under these difficult circumstances.

The Department of Public Welfare was thought to be competently staffed. Its first director, Charles H. Thorne, was a business executive of experience and skill possessed of a broad, humane view of the Department's responsibilities. As Superintendent of Charities, Mr. A. L. Bowen had a familiarity with the state institutions and their problems gained from his seven years service as secretary of the State Charities Commission. The State Alienist, Dr. H. Douglas Singer, was a competent and experienced psychiatrist; he also had the assistance of Dr. Zeller, alienist member of the preceding Board of Administration, and retained as Managing Officer of the new Alton State Hospital. The combination of administrative officials was an auspicious one.

The war situation created a group of acute problems in institutional administration. Prices for all supplies advanced rapidly, bringing great strains on budgetary estimates and appropriations. Because of the national food control measures, supplies of some necessary foods were small or nonexistent; other foods had to be substituted. With price levels inflated by the war situation, fiscal plans of the Department were constantly upset. Added to this difficulty was the adaptation to the new

process of purchasing through the related Department of Finance. Moreover, building materials and building-trades wages advanced so sharply that contemplated new construction was abandoned; overcrowding promptly resulted.

The most acute problem, however, was that of personnel. The war-footing of the nation drained off man power to the essential industries; other employees were drafted for military service, with the result that attendant staffs were depleted to dangerously low levels. Even more severe was the drain on medical staff. Physicians and nurses were drawn into military and Red Cross Service; the hospitals were left with the barest of skeleton staffs. These conditions, moreover, reacted internally to make institutional service unattractive because of the disruption of working conditions and the large patient loads thrown on each staff member. That a real state of emergency existed is evidenced in the departmental reports of the period, conveniently summed up in the Governor's Message in 1919:

Public Welfare Problems

Perhaps the Department of Public Welfare has labored, during the war, under greater difficulties than any other department of our government. Though the minimum wages of attendants were increased 40 per cent, it was impossible to secure competent attendants in anything like sufficient numbers. The drafts specially made upon physicians and nurses in the service by the War Department and the Red Cross threatened to demoralize the service. In some instances, the entire medical staff of a hospital, with the exception of the superintendent, was changed twice during the war. At one time the situation was so serious that I deemed it necessary to make a direct public appeal to the people to engage in the necessary work at the State institutions in order that we might not have to close them.¹

However, even in the disturbed days of these early years, there was formulation of departmental policy, and some steps were taken toward necessary services. The first report of the Director affirms principles of sound administration for the Department, and, pertinently, stresses the need for broader services than mere institutional care. "1. Until the state begins to insure itself against the future by premiums paid for preventive treat-

¹Extract from Biennial Message of Frank O. Lowden, Governor of Illinois, to the Fifty-first General Assembly, January 8, 1919, p. 5.

ment, it will never have the facilities for the care of the incompetent equal to the demand."¹

A move toward such preventive treatment is indicated in the Director's report for 1920; it notes that out-patient clinics have been established at Chicago, Jacksonville, and Peoria State Hospitals--"upon the theory that it is cheaper and more effective for the hospital to go to the people than to wait for the people to come to the hospital."²

The Superintendent of the Charities notes that beginnings had been made of a school of nursing, that classes for attendants had been formed in all hospitals, and that occupational therapy had been introduced.³ Social service work had also been started with at least one worker provided for each hospital.

The first report of the Alienist is significant for its definition of his function. This definition is included here, both for its content, and because of later confusion about his function and deviation from this concept of it.

The function of the Alienist, of The Department of Public Welfare may be concisely stated as follows:

To devise policies concerning general or special medical treatment, care and after-care of patients suffering from insanity, epilepsy, feeble-mindedness and dependency, and concerning the prevention of these conditions.

To direct scientific investigations in the State Psychopathic Institute and in the institutions of the insane and charitable groups, with the exception of the schools at St. Charles and Geneva.

GENERAL PRINCIPLES

The work may be conveniently considered under two headings:

- (1) The care and treatment of persons committed to institutions.
- (2) The after-care of such individuals when released from institutions to avoid recurrence. With this may also be included
- (3) The most⁴ important problem of all, that of primary prevention.

¹Department of Public Welfare, Annual Report, 1918, p. 226, Report of the Director.

²Ibid., 1920, p. 12.

³Under the competent direction of Eleanor Clark Slagle.

⁴Department of Public Welfare, Annual Report, 1918, p. 275, Report of the Alienist.

The initial inclusion of after-care and preventive services in the Department's program is noteworthy. There was also due appreciation of the fact that proper after-care was to be had only through the use of trained social workers. The Alienist's report refers to a so-called Social Service School which was really a device for in-service training, and continues:

The Social Service School will be pushed and the services of trained workers for after-care work be extended to all institutions. With their assistance it will be possible to release patients from the institutions who would otherwise be obliged to stay.¹

The "Social Service School" referred to was that organized in January, 1918, in connection with the Social Service Department of the Juvenile Psychopathic Institute.² This training "school" had an auspicious beginning under the officials of the Lowden administration. The project for training workers for the state hospitals was, however, abandoned in the succeeding administration.

Following the hectic days of the war period, the personnel situation was somewhat eased by 1920. The pressures of the war activity were relaxed; staff, both attendant and medical, returned from war service to their former posts. Political interference in staff appointments appears to have been at a minimum. In his report for 1920, the Superintendent of Charities states:

To this end [the promotion of high standards of care for the mentally ill], all semblances of politics have been eliminated from the state charitable institutions. Superintendencies have been filled by promotion on merit of men who have made good in the lower medical ranks.³

It would be surprising indeed to find in Illinois that "all semblances of politics have been eliminated." However, in support of the Superintendent's claim, an examination of the movement of managing officers during the Lowden administration

¹Ibid., p. 277.

²See p. 119 for a more detailed account of this development.

³Department of Public Welfare, Annual Report, 1920, p. 36, Superintendent of Charities.

lends support to his statement. Of managing officers, there were seven changes during the period. Of these, four were transfers between hospitals, and two were promotions from the rank of assistant managing officer. Only one was a new appointment, and he had previously served as managing officer for six years at another state hospital. One continued uninterruptedly through the period. Among assistant managing officers there were ten changes; of these seven were promotions from lower ranks and three were transfers; there were no new appointments, and one continued in service unchanged through the period. Personnel changes in these ranks, then, confirm the Superintendent's statement. In the attendant staff, it was so difficult to secure any personnel from any source that political influence was undoubtedly a small factor in appointments.

There appears, therefore, to have been good observance of merit principles in staff selection during the period--an observance aided by the acute scarcity of competent personnel at all levels. Unfortunately, this favorable practice ended with the Lowden administration, and the subsequent history is one of abandonment and prostitution of the merit principle.

The new Department had its advisory body, the Board of Public Welfare Commissioners, an unpaid Board of five members. This Board was not, however, co-ordinate with the Director. They were appointed by the Governor just as he was, but their budget went to the Governor and the legislature through the Director, and they therefore felt themselves somewhat subordinate. The members were: Dr. E. C. Dudley, Chairman; Dr. Frank P. Norbury of Springfield; Rabbi Emil G. Hirsch of Chicago; Benjamin R. Burroughs of Edwardsville; and Dr. Edwin C. Hayes of Urbana. Two of these members brought valuable experience to the Board. Rabbi Hirsch had been an active member of the Deneen Board of Charities for the preceding eleven years. Dr. Norbury had an intimate acquaintance with institutional problems from his two years service as Managing Officer at Kankakee, and later as alienist member of the Board of Administration. Dr. Dudley was a distinguished and public spirited physician, Mr. Burroughs an appellate court judge, and Dr. Hayes a professor of sociology at the state university. Dr. Dudley and Dr. Hayes, after a difference of opinion with the Director, resigned so that they served only two years, resigning

in 1918. Only one appointment was made to these two vacancies, that of Miss Amelia B. Sears, a social worker of Chicago, who served from September, 1918, until January, 1921.

Thus, for the second biennium of its service the Board had only four members. This was the first appearance of a primary weakness in the Department's administrative structure--the appointment of the Board was not mandatory on the Governor; there could be a full board, a partial board, or no board at all as he elected. Moreover, the Board, full or partial, was subordinated to the Director; he controlled both its budget and its appropriations, and hence its very existence and the quality of its activity. The Board, therefore, existed only by the goodwill of both the Governor and the Director. The shadow of its subsequent decline was already appearing on the wall.

The work of the Board of Public Welfare Commissioners during the period was influenced by its anomalous position in relation to the Department. It had a legacy of purpose and experience from the Deneen Board of Charities but lacked the powers and drive to continue its outstanding work. Under the old Board of Charities, the Board itself had a real supervisory and planning function in integrating the work of the separate state institutions. Much of this function was taken over by the Board of Administration in the centralized administrative process. However, there was left to the State Charities Commission important planning and advisory functions which it effectively discharged.

The Department, however, was given such broad powers of administration within itself, including its technical advisers of Alienist and Criminologist, that little of an advisory nature was left to the Board of Welfare Commissioners. Its powers were limited to those of regular and special inspections and report, and to the collection of statistics on insanity and crime. The latter function was logically one for the Department itself and in 1920 it introduced a new uniform system of statistics, and took over that responsibility. This left the Board with only the inspectional function, vague in both purpose and definition.

This vagueness was accentuated by the weakness of its secretarial personnel. Mr. Bowen, secretary to the former Board of Charities, was now Superintendent of Charities within the Department, and took with him much of the inspectional and super-

visory attitude and powers. He was not replaced by the Board, which was given part-time executive assistance by Miss Anne Hinricksen. Miss Hinricksen, however, also occupied the post of Assistant Superintendent of Charities within the Department, and as such, was responsible to the Superintendent of Charities and the Director of the Department. She continued in this dual capacity throughout the Lowden administration, and her reports of inspectional visits to institutions were included variously in the Departmental report or the report of the Board, occasionally under both heads.¹ That she functioned as an active departmental official is also evidenced by the fact that she served as Acting Managing Officer of the State Training School for Girls during May and June, 1919, in the absence of the Managing Officer.²

Further evidence of this confusion is presented in the program of the Board, as decided in their meeting of January, 1918.³ It set out three objectives for its work:

1. The revision of court procedure in the commitment of insane and criminal persons.
2. The introduction or furthering of industrialization of the state institutions.
3. The development of farm colonies connected with the institutions.

Of these three objectives, it would appear that the two latter were proper phases of planning and policy to be handled by the Department itself. In fact, the reports of the Superintendent of Charities in 1918 and 1920, refer to both activities. No further mention appears of the first objective, the revision of court procedure nor of the steps taken to achieve it.

The activities of the Board soon relapsed into a passive acceptance of the inspectional work of its part time executive secretary, and the publication of the statistics which she com-

¹See Board of Public Welfare Commissioners, First Annual Report. Institution Quarterly, December, 1918, p. 203. Also, Department of Public Welfare, Annual Report, 1919, Report of the Superintendent of Charities

²Department of Public Welfare, Annual Report, 1920, p. 271, Biennial Report of the Board of Public Welfare Commissioners.

³Institution Quarterly, March, 1918.

piled. That they later viewed their function as little more than this appears in their final report.

Co-operation with the Department of Public Welfare

The relation between the Commission and the Director of Public Welfare have been those of assistance, co-operation and loyal support. These relations are the result of a definite policy on the part of both the Commission and the Director. The executive secretary was instructed by the Commission to give the Director every possible assistance and to use all of the resources of the Commission for this purpose. In return, the Director has furthered the work of the Commission by placing at our service the resources of the Department of Public Welfare.

This policy has not interfered with the freedom of thought and action on the part of the Commission. Independent investigations, inspections, and surveys have been made. Criticisms, when necessary, have been frank. But the spirit of our work has been throughout one of co-operation and we believe that by this spirit alone can we best serve the interests of the public welfare service.¹

The achievement of "co-operation" with the Department apparently became a major objective. In short, the functions of critical evaluation, initiative or leadership had in reality passed from the Board to the Department, where they were exercised, if at all. The Board had ceased to have any independent status or positive purpose.

The "Small" Administration

The Lowden administration was succeeded by that of Governor Len Small, who took office in January, 1921. Governor Small served two terms, 1921-24 and 1925 through 1928. This period was a critical one for public welfare administration. The new department was taking shape after the upset conditions of the war years. Its planning was beginning to be effective; some personnel standards had been set up; the Institute for Juvenile Research had been established, and plans for the Research and Educational Hospitals worked out. The ensuing period should have been one of consolidation of these gains and further progress. Unfortunately it was not so; rather it turned out to be a period of disorganization and backsliding in the hospital administration.

¹Department of Public Welfare, Annual Report, 1920, p. 273, Biennial Report of the Board of Public Welfare Commissioners.

Governor Small's party was Republican, succeeding the Republican administration of Governor Lowden. But Governor Small was the candidate of another faction of the Republican party, and the rivalry between the two factions of the same party was at least as strong as between the Republican and Democratic groups. In any event, the advent of Mr. Small as Governor was the occasion for a wide purging of existing office-holders and the appointment of "Small's men" to the posts. In the Department of Public Welfare, the result was a tragic one and brought in its wake eight years of insecurity and disorganization, in executive posts and rank-and-file alike.

The loss of leadership was most acute at the executive levels, because of the large problems still facing the young department. There was little carry-over of personnel or experience from the previous administration. Mr. Thorne, the previous director, was replaced by Mr. C. H. Jenkins of Springfield, a former judge of the County Court. During his judgeship, he had had some contact with the problems of public welfare, but was lacking in previous administrative experience. As Superintendent of Charities, Mr. Bowen, with twelve years of experience, was replaced by Mr. Lawrence H. Becherer, a political party worker without any previous contact with welfare problems. As Alienist, Dr. Charles F. Read replaced Dr. Singer; Dr. Read was a psychiatrist of good experience and ability, and came to the post with a wide acquaintance with the Illinois hospitals. Joining the state service in 1910, he had served in most of the large institutions and for the preceding four years had been managing officer of the Chicago State Hospital. In view of the newness of the other officers of the Department, his broad experience could have been of large value to them; the reverse, however, occurred, and his period of office was shortened by the lack of recognition and response given to his recommendations.

Such were the officials to whom the mental services were entrusted by the new Governor. Within themselves, the hospitals might have suffered less from these changes if their own staffs had been retained. Unfortunately they were not. The advent of Governor Small brought changes of managing officers in half the hospitals; three managing officers "resigned," and one was promoted to Alienist. The four vacancies thus created were filled

by the appointment of four new managing officers, all of whom were practicing physicians, but none of whom had special psychiatric training or institutional administrative experience. Nor was there any promotion of an assistant managing officer to the higher rank.

Though the assistant managing officers were spared a "purging," they were hardly a stabilizing factor in the hospital administration, because of the transfers which were made among them. In the four years of Governor Small's first term, seven of the eight hospitals had changes of assistant managing officer; one only had no change. Of the seven hospitals which had changes, three had one change during the period, two had two changes and two had three changes; of the latter four, two were among those hospitals which also had a change of managing officer to add to their insecurity. Four assistant managing officers resigned during the period, three of these in succession from the same hospital. Another large hospital with a newly appointed managing officer was left without an assistant managing officer for the last three years of the four-year period.

With this change and confusion among department officials and executive officers, it is not surprising to find a heavy turnover among the lower staff. Total figures for the movement of employees first appear in the Report of the Statistician for the fiscal years 1923-24 (year ending June 30, 1924). In that period there were 2,993 employees (all ranks) on the payroll at the beginning of the year, 2,855 at the end of the year, an average of 2,828 employees. To maintain this number there were 2,993 additions to the payroll, 2,465 newly engaged, and 528 returns from leave. The total number on the payroll during the year was 5,789, to maintain an average payroll of 2,825 employees, or a turnover ratio of 2.05. There was therefore the equivalent of two complete turnovers of the staff during the year.

Part of this large turnover was doubtless a legacy of the upset conditions of the earlier period; how large the turnover was previously we have no statistical information. But it is significant that in the third year of his administration, six years after the war period, when economic conditions were again normal, this high rate still existed. Certainly internal conditions in the hospitals must be looked to for explanation, and

these explanations are amply provided in the departmental reports for the period.

Dr. C. H. Anderson, Managing Officer of Anna State Hospital (a Lowden appointee), describes conditions at that hospital as follows:

Medical

That we are not able to claim substantial improvement in the medical service is a cause of profound regret. The medical profession, like commercial affairs, has not returned to normalcy since the war The emoluments offered as a reward for private are so much greater than those offered by the state service that young men with a future are rarely drawn into the charities service.

The housing conditions in the Anna State Hospital are, as most other hospitals, quite uninviting.

The nursing service is handicapped for want of trained nurses. The number of pupil nurses is so far below the number that should be in training because so few of our employees have the required preliminary education.

The necessity for economy caused the fifty-second general assembly to reduce the amount appropriated for extraordinary repairs to bare necessities.¹

The same report shows a heavy turnover of employees--115 were added to the staff during the year, and there were 110 separations.

There was great difficulty in retaining medical staff, as indicated above. How desperate the situation was at Anna is indicated by the excerpt below, showing the changes in medical staff for the year.

Changes in Medical Personnel, Anna State Hospital, 1922-23:²

¹Department of Public Welfare, Annual Report, 1923, p. 153, Report of the Managing Officer of Anna State Hospital.

²Compiled from data in the report of the Managing Officer, Anna State Hospital. Department of Public Welfare, Annual Report, 1923, supplemented by the personnel file of the Department of Public Welfare, Springfield.

The Managing Officer comments on the above changes as follows: "The unusual number of changes was brought about by circumstance over which the Department had no control" (ibid., p. 137).

<u>Name</u>	<u>Rank</u>	<u>Date of Appoint- ment</u>	<u>Date of Separa- tion</u>	<u>Period of Service</u>	<u>Remarks</u>
Dr. Gaffey	A.P.*	6/23/22	6/31/22	1 week	Resigned
Dr. Rose	A.P.	9/22/21	9/11/22	12 months	Resigned
Dr. Dietz	A.P.	4/17/22	10/21/22	6 months	Resigned
Dr. Quitzreau	A.P.	4/6/22	10/21/22	6 months	Resigned
Dr. Randolph	A.P.	1915	1/1/23	8 years	Resigned
Dr. Church	A.P.	1/9/23	7/5/24	18 months	Resigned
Dr. Nobles	A.P.	1/9/23			Continued
Dr. Kilgour	A.P.	2/2/23	9/30/24		Transferred out
Dr. Beattie	A.P.	1910	3/28/23	13 years	Died
Dr. Fish	A.M.O.*	5/1/23			Transferred in

*A.P. - Assistant Physician

A.M.O. - Assistant Managing Officer

A summary of the table given above shows that during the period five staff members resigned and one died; to fill these vacancies three new assistant physicians were appointed, and an assistant managing officer was transferred. (The hospital had been without an assistant managing officer for the previous year.) During the three autumn months the only staff present were the managing officer, one physician, and one assistant physician--to care for some 1,800 patients.

Much the same conditions were evident in the same hospital two years later. For the fiscal year 1924-25, the Managing Officer reports five new appointments to the medical staff; of these four soon resigned after periods of service of three weeks, five weeks, three months and five months respectively; the fifth served sixteen months and transferred to another hospital. In the same year an assistant physician resigned after eighteen months' service; a second was transferred after eighteen months' service. Apparently, however, the Managing Officer had now become inured to the constant changes as his only comment is: "We are pleased to report that the personnel of the medical staff has materially improved during the past year. Individual attention

to the patients has been our objective."¹ No explanation is given as to how "individual attention" was afforded the patients, with such a staff shortage and constant turnover.

The staff situation of Alton (1,250 patients) was equally confused--a confusion which is reflected in the report of that institution for 1924.² The excerpt may be summarized: The hos-

¹Department of Public Welfare, Annual Report, 1925, p. 153, Report of the Managing Officer of Anna State Hospital.

²The following changes in the medical staff during the fiscal year are reported by the Managing Officer of the Alton State Hospital, ibid., 1924, p. 189.

Dr. R. A. McAllister, dentist, resigned July 2, 1923.

Dr. Max O. Wolfe reported for duty August 6, 1923, and was transferred to Watertown State Hospital, June 14, 1924.

Dr. B. F. Tate, dentist, reported for duty September 6, 1923, and resigned on November 11, 1923.

Dr. E. J. Cohn reported for duty September 24, 1923, and was transferred to Jacksonville State Hospital, October 13, 1923.

Dr. W. J. Cavanaugh resigned September 30, 1923.

Dr. F. H. Glasco resigned October 13, 1923.

Dr. T. L. Gramay was transferred from the Watertown State Hospital to the Alton State Hospital, October 24, 1923. He died March 14, 1924.

Dr. A. C. Ragsdale reported for duty October 24, 1923. He died March 14, 1924.

Dr. E. Ratcliff reported for duty January 19, 1924.

Dr. G. I. Allen, dentist, reported for duty February 19, 1924.

Dr. E. L. Mize was transferred from the Jacksonville State Hospital to the Alton State Hospital, March 24, 1924.

Dr. W. H. Meyer reported for duty April 10, 1924, and resigned May 30, 1924.

Dr. P. S. Waters, Assistant Managing Officer, was transferred to the Peoria State Hospital, May 16, 1924.

Dr. J. J. Walsh, Assistant Managing Officer, was transferred from the Peoria State Hospital May 16, 1924.

Dr. Peter Vanderleek reported for duty at this hospital, June 3, 1923.

It is significant that this statement of staff changes is the

pital, although it was without dental service for five out of the twelve months, had three dentists during the period; gaps of two months and three months occurred between the term of one and the appointment of a successor. Of the medical staff present at the beginning of the year, the Managing Officer was the only person who did not change; he was a new appointee a year previously. There was a change of assistant managing officers. Of the "older staff" two resigned during the year, with services of nine months and sixteen months respectively. There were eight new staff appointed or transferred. Of these, two died, each after five months' service, and four resigned with services of one, two, seven, and ten months respectively. Two continued on, with eventual service of three years each. There was, apart from the managing officer and assistant, no senior medical staff serving during the year.

The situation in the upstate hospitals was somewhat more stable but they remained much understaffed. At Chicago, with 3,150 patients, there was a continuous staff of ten¹--the Managing Officer and assistant, two senior physicians and six junior physicians; there were three resignations and four appointments. Elgin, with 2,900 patients, maintained a continuous staff of six, with three appointments and one resignation. Kankakee, with 3,500 patients, also had a continuous staff of six, with three appointments. The small size of these staffs, however, meant impossibly large patient loads for each physician with the inevitable result of casual treatment. That this condition was of concern to the Alienist is indicated by his successive reports.

The first report² of the new Alienist refers to the unsettlement of the post-war period, and the consequent difficulty of retaining staff. During the year twenty-five physicians had entered the state service; at the end only fourteen remained, and

major part of the report for the year. It is followed by a page enumerating improvements in the plant. Nothing is stated in the report about the patients.

¹Department of Public Welfare, Annual Report, 1924, Report of the Managing Officer of Chicago State Hospital.

²Ibid., 1921, p. 31, Report of the Alienist.

eighteen others had resigned--the state service was being drained of its experienced physicians. The situation continued unimproved, and the next year the Alienist in a vigorous report¹ presented an analysis of the causes. Chief among these were (1) the low salary scale, which failed to attract competent men, (2) unsatisfying living quarters, (3) the routine and unproductive nature of the work, and the lack of professional qualities and opportunities in it. Related to this was the lack of contact with medical societies, libraries, and research work. (4) The inadequate medical staffs resulted in such heavy loads and responsibilities that the existing staff became discouraged and left the service.

As a remedy for these causes a constructive program was set out, including better housing for medical officers and their families, salary increases, and the strengthening of professional attitudes and experience by additional staff and facilities for professional work. That much broader facilities for professional training were needed is indicated by the previous report² of the Alienist, in which he pointed out that the only formal training facilities available for medical staff were provided by his occasional visits to the various hospitals. At these times, along with other pressing duties, he attempted to hold staff meetings for clinical instruction.

The discouraging outlook with the attendant forces is well set out by the Alienist in his report for 1923:

Attendants.

The attendant force remains a shifting, variable quantity; the turnover is large and it is difficult to secure enough single women. There are also a considerable number of discharged and worthless employees traveling from one institution to another where they register under various names. The training of the attendant body goes on as in former years--a four months course--at the end of which time, unfortunately, many of those who began the course have already been discharged or resigned.³

His comments on nursing, medical staff, and overcrowding are

¹Ibid., 1922, p. 51.

²Ibid., 1921, Report of the Alienist.

³Ibid., 1923, p. 53.

equally pointed:

Staff ratios and overcrowding

We have not enough trained employees and a number of the wards of the various hospitals show the result of this lack. Upon the whole the sick wards are well cared for, but unfortunately the remainder of the institution usually suffers--principally the more deteriorated patients and those upon the infirmary wards. Illinois could very well use 100 more graduate nurses than are upon duty today: for while the attendant force is the back-bone of the nursing organization, the trained graduate of our schools is, upon the whole its brain, and soul as well--a remark which, however, does not apply to a few efficient attendants in each institution who are daily giving their best efforts, the result of years of practical training, to the care of our unfortunates.

Medical Care

An increase of some fifteen physicians is most desirable. Under the existing circumstances it is not rare for a physician in one of the larger institutions to have charge of 1,000 patients, sometimes for a day, often for weeks, and occasionally even for months at a time. Under these conditions it is of course impossible to individualize care and treatment.

Crowding

The northern tier of institutions, Chicago, Kankakee and Elgin are still much overcrowded although they have all been relieved by transfers of patients during the year. This crowding is not only unsanitary but contributes to irritability and violence and thus to a prolongation of the hospital sojourn.¹

The overcrowding of the hospitals was steadily becoming more severe. The annual increment of patients was about 450 per year, and housing for only a fraction of this number was provided by the Department's building program. The situation was acutely worsened by a fire at the Chicago State Hospital on December 26, 1923, which consumed four wards and the dining room, and caused the death of sixteen patients and two attendants. The buildings burned were of old, flimsy construction, originally designed as summer pavilions for tuberculous patients, and forced into year round use because of the pressure for space. The coroner's jury sharply called attention to the continuing dangers of using old, overcrowded buildings, and called on the Department and the Legislature to remedy the overcrowding at Chicago and the other state hospitals.

¹Ibid., p. 53.

The loss of the Chicago wards caused more acute overcrowding than ever in the upstate hospitals. In his report for 1924, the Alienist pointed out the impossibility of treatment under such conditions. The following excerpt on the care of patients is convincing:

Crowded Conditions You are already aware of the fact that the institutions caring for patients in the northern part of the state are terribly overcrowded, more so this year even than last, owing to the reduction in capacity of the Chicago State Hospital consequent upon the fire in December, 1923. At the Kankakee State Hospital but little bed capacity has been added while the population has increased by about 500. At the Elgin State Hospital the receiving ward for men is regularly listed as carrying from 50 to 60 over capacity, that is some 60 patients must sleep upon the floor or upon cots each night, and during the day about 90 men are so huddled together that recovery or improvement is prevented or delayed unnecessarily long. Conditions upon the female receiving ward are about the same and all wards save those for ex-service men are crowded beyond description. Sane people housed under such conditions would suffer mentally, would quarrel and become physically ill.

Under present conditions it is quite impossible to provide proper medical and nursing care. Whichever way we turn in questions of treatment we are blocked by lack of space. For example, at Elgin it is desirable to establish wards for the observation and care of paralytics under special treatment; at Chicago State Hospital ward for the treatment of mental disorders following lethargic encephalitis; at Peoria State Hospital, wards for the habit training of patients, etc. None of these things can be done because there is not room.¹

During the year some progress had been made with occupational therapy. A new director had been appointed, and some training of staff begun. The Alienist calls for its extension, pointing out that much of the so-called "therapeutic work" was mere institutional maintenance, devoid both of interest and of therapeutic value to the patient.

An efficient Occupational Therapy department cannot be operated without a trained chief aid and proper equipment and materials. The cutting and sewing of carpet rags, the raveling of potato sacks and weaving of rag rugs do not constitute diversified nor interesting enough activities even for delapidated cases. . . . The chief danger of this work lies in its becoming too much a matter of routine. A squirrel cage type of work is not therapy at all. It is merely occupation and such occupation, though as a rule better than none at all, may in certain products become actually detrimental. The

¹Ibid., 1924, p. 37.

making of certain products with which to beautify the wards, such as curtains, rugs, cushion coverings, etc., is desirable only if at the same time the patient's need for training and re-education are being fully met.¹

At the same time he urged the broad extension of active recreation activities to reach every possible patient. He depreciated the acceptance of passive interests such as concerts and movies for the patients, pointing out that these encouraged their already too sedentary and detached habits. There was largest need for simple, active group activities, such as music, games, simple athletics, and the like, in which large numbers could participate and be benefited by the physical activity and heightened social co-operation.

This sound and necessary program, urged year after year by the Alienist, met with indifferent reception by the administrative officers of the Department. There was apparently faint awareness on their part of the therapeutic purpose of the hospitals or of their urgent need of buildings and equipment, competent staff, and positive program. Year after year of inaction passed by, with the whole hospital situation dismissed by a casual wave of the hand, as indicated by the following excerpts from the reports of the Director: "The work of the staffs of the various hospitals has been of a satisfactory character."² "It is my impression that while some of the staffs are as yet unmanned they are on a whole stronger than they have been at any time since the World War and are accomplishing better results."³

Hospitals for Mental and Nervous Diseases

These institutions continue to serve their purpose every year with greater efficiency and success. On the whole, they have been well managed and successfully conducted.⁴

The Superintendent of Charities, who had direct responsibility for the hospitals, gives them scanty mention in his first two reports; nowhere can be found any statement of purpose or policy with respect to them. Further indecision was brought into Departmental administration by the resignation of the Superintend-

¹Ibid., p. 41.

²Ibid., 1923, p. 12, Report of the Director.

³Ibid., 1925, p. 15.

⁴Ibid., 1926, p. 9.

ent of Charities, Mr. Becherer, in July, 1923, after two years in office. His successor was Mr. Edwin B. Brooks, of Newton, who had been a Superintendent of Schools in Jasper County (population 12,800) for twenty-two years, and Congressman for six years. His reports contain nothing but a brief listing of the institutions, with the number of patients and the physical improvements at each.

With such indifference to the state's responsibilities for its wards, and to their urgent needs, it is not surprising that the Alienist soon became discouraged. After persistently calling attention to the worsening conditions in the hospitals, without response, he resigned on June 30, 1925, after four years of office. With his departure, the Department lost the only competent source of advice which it had had on the care of the insane. How little it felt the need for such guidance is indicated by the fact that the post of Alienist went vacant for nearly two years following.

The Second "Small" Administration

The second period of the Small administration was marked by increasing disorganization of the hospital administration within the Department. There was no Alienist to stimulate the professional work of the hospitals. The new Superintendent of Charities conceived his position as an inspectional and supervisory one:

During the first nine months of the year I was acting Managing Officer at the Lincoln State School and Colony; up to the first of April. During the entire month of June I relieved at the Jacksonville State Hospital as Managing Officer. The remainder of the year, about sixty days, I spent in regular visitation work at the various institutions.¹

Since I have been located a great deal of the time at the Jacksonville State Hospital it has been impossible for me to visit some of the institutions.²

In his second year of office he was diverted into the post of Acting Managing Officer of the Lincoln State School and Colony (for mentally deficient), a post which he continued to occupy for two years.³ For a period of some months following, he substituted as Managing Officer at Jacksonville State Hospital.⁴ He apparently

¹Ibid., 1927, p. 11, Report of the Superintendent of Charities.

²Ibid., 1928, p. 22. ³Ibid., 1927. ⁴Ibid., 1928.

made sporadic trips of inspection to some other institution in time taken from these institutional activities.

The administrative absurdity of this situation is apparent. An official of the Department, charged with the large supervisory responsibilities, demoted himself to the post of Managing Officer of a single institution--a post for which he has had neither training nor experience. The complicated problems arising in a training institution for 3,000 mentally deficient children were hardly to be met by such offhand administration. And what of the welfare of the 3,100 patients at Jacksonville? No report of that institution was made for the year 1926-27, and while the former Managing Officer was continued on the rolls he apparently was not functioning in that office. Nor was any Assistant Managing Officer appointed. The welfare of the 3,100 patients was left to the mercy of a lay administrator, without an assistant, four permanent physicians, and six others in and out during the two year period. Meanwhile the work of the Superintendent of Charities, if carried on at all, was carried on by assistants.¹

Further dislocation of the administrative hierarchy was provided by a change of Directors in March, 1927. Judge Jenkins resigned, and was replaced by Mr. Roy W. Ide. Mr. Ide was a resident of Springfield, a man of independent means, but without previous administrative training or experience for such a responsible post. His good intentions were a weak substitute for the firm administrative hand which the Department so badly needed at the time.

At this point, too, a new Alienist had been appointed, Dr. Alex S. Hershfield, of Chicago. In his two years of office, however, it is not apparent that the new Alienist had any useful conception of the work of the hospitals or of their tremendous unmet needs. The only report for a full year is that of 1927-28, in which is stated:

¹Vacancies in executive posts also occurred elsewhere in the Department. The important office of Fiscal Supervisor, created by the Code, was vacant from May, 1922, until May, 1926. During this time its former incumbent, Colonel Frank D. Whipp, an experienced and able administrator, was acting as Managing Officer of the St. Charles School for Boys.

The State Alienist has visited the various State Hospitals as has been needed to lecture of the staffs in such a way as to improve the medical work. Every state hospital has its full quota of excellent physicians working harmoniously and the future looks bright for improved work for the benefit of the patients.¹

That the actual conditions existing were sharply different from the Alienist's statement can be found from the Departmental report of the same year. All of the hospitals had managing officers, except Jacksonville, where the Superintendent of Charities had installed himself. Four of the eight had assistant managing officers steadily during the year; two others experienced transfers; one received such an officer after a vacancy of six years, and another remained vacant through the years. There were a total of eighty-one medical officers in service at the end of the year, including managing officers and assistants; there were twenty-two senior physicians and thirty-one junior physicians and internes. The patient load, counting all medical officers, was 275 per physician, but if the administrative officers are excluded this load rises to 418 per physician (and many of these physicians were new and untrained). The minimum standards of the American Psychiatric Association, stressed by the previous Alienist, called for a maximum patient load per active physician of 250 patients. The gross excess in the Illinois situation is apparent.

Moreover, the situation in particular hospitals was more acute. Alton, with 1,400 patients, had no senior physicians on its staff (except the Assistant Managing Officer), and only two junior physicians. East Moline, with 1,900 patients, had secured an Assistant Managing Officer after a vacancy of six years, and had additionally only three senior physicians and one junior physician. Elgin, with 3,200 patients, had only one senior physician and one junior physician steadily during the year; there were five resignation of transfers, and four new appointments. Peoria, with 2,700 patients, had a change of Assistant Managing Officer during the year; had only one senior physician and four junior physicians; all the latter were new appointments.

Staff turnover continued to be a serious problem. In the

¹Department of Public Welfare, Annual Report, 1928, p. 24, Report of the Alienist.

year, there were 2,005 additions to staff and 1,947 separations, to maintain an average payroll of 3,207--a turnover ratio of 1.61. Of the separations, 1,274 employees, 40 per cent of the total staff, resigned during the year, 363 others were discharged. The "harmony" achieved by overloaded physicians working under this constant turnover of attendant staff certainly contained more discords than reached the ear of the all-too-detached Alienist.

Overcrowding remained acute. The annual increase of patients in the hospitals during the eight years of the Small administration averaged 405 patients per year. During the first four years little new construction was undertaken; patients simply piled up in the already overcrowded wards. The fire at Chicago State Hospital made the situation sharply worse. In the second four years more building was undertaken; this construction, however, was only a fraction of what was needed for current increases, let alone the accumulations of past years. In these four years some 1,300 additional beds were made available for insane patients; the total patient increment in the eight years was 3,239 patients; hence overcrowding remained acute, and was particularly severe in the northern hospitals.

The administration's patent neglect of the real problems facing the hospitals was made the more offensive by its showy attempts to flaunt its "progress." After the resignation of Dr. Read as Alienist, little information on the state of the hospitals could be had from any of the state publications. The annual reports of the Department, and of individual hospitals, were fragmentary and often misleading. The Institution Quarterly, established by the Board of Administration in 1909, was continued by the Department, and is the chief source of information with reference to the activities of the Lowden Administration. With the Small regime, the Quarterly abandoned factual reporting and contained largely "popular" writeups of scattered, unrelated topics; this content continued through 1925.

Following a nine-month gap in publication, there appeared in September, 1926, a new journal, The Welfare Magazine, in magazine format and pretentious appearance. Its contents, however, had little relation to the work of the Department. It contained popular and "feature" articles of sentimental tone; many pictures and eulogies of Governor Small, the Department officers, and the

institutions, but little or no information as to the Department's program. This flamboyant effort, which continued until abolished by the succeeding administration, was staffed by an editor and two associates (all full time) at a period when the Department had neither Alienist nor Superintendent of Charities to guide its course. And as a final piece of effrontery the fly leaf of the magazine carried the following sentiment:

May we fight a Good Fight;
May we keep the Faith;
May We continue to Keep
this Publication From Being
Used as a Vehicle to
Further any Political End.

The unconscious irony of this inscription well symbolizes the despoiling character of the administration which it represented

A word should be said at this point about the reorganization of social service work in the hospitals. The development of the work is fully set out below,¹ but it is to be noted that in the last year of the Small regime, some effort was made at its improvement. Developed under the Lowden regime, it had continued while Dr. Read was Alienist, but subsequently lapsed into neglect or perfunctory performance. On July 1, 1928, the present Chief of Social Service work in State Institutions was appointed, and proceeded to organize that Division. It is significant that her appointment came through the efforts of Dr. Herman Adler, the State Criminologist, and that she was carried on that payroll through the Small Administration.² The incumbent Alienist had no part or interest in this significant development, so vital to good hospital administration and to the patients' welfare.

It may well be asked: What was the Board of Welfare Commissioners doing during this period of disorganization? The answer is perhaps a fitting finale to the story of the Small regime--most of the time it was nonexistent. No official voice was raised in protest against the increasing demoralization of the Department.

Since the terms of Commissioners are those of the appoint-

¹See below, pp. 118 ff.

²Information from Mrs. Margaret Moffit Platner, Chief of Social Service in Institutions, by interview, July, 1938.

ing Governor, the terms of all the members of the Lowden Board expired with his term of office. Governor Small did not want the Board; his State budgets for the bienniums 1921-23, and 1923-25, included no item for it, and no appointment was made until 1923. After two years of nonexistence, a gesture was then made in the appointment of Judge Perry L. Persons of Waukegan; Judge Persons was the County Judge of Lake County. No other members were named and since no appropriation existed the appointment was meaningless. The two bienniums of the second Small administration each carried appropriations of \$28,790 for the Board; however they were never used for that purpose. Four additional members were named in 1927--Willoughby Walling of Chicago, Mrs. Minnie J. Berlin of Chicago, Mrs. Margaret Cade of Chicago, and Right Reverend James A. Griffin of Springfield. No chairman of the Board was named, however, and there is no record that it was ever convened.

During the eight years of the Small administration, then, there was no Board of Public Welfare Commissioners. At the time of the Department's greatest need, there was no one to speak out boldly for it and its human wards; to protest the viciousness of overcrowding and the tragic lack of medical personnel; to point out the stupidity of an administrative hierarchy, responsible for the care, training and therapy of 35,000 state wards, which was largely untrained and irresponsible, and during a critical four-year period, was weak and disorganized to a dangerous degree. That such a failure could exist revealed a glaring weakness in the Administrative Code; that it did exist reflects the insolent attitude of the political machine toward any decent or humane standards of public welfare administration.

The Emmerson Administration, 1928-1932

In January, 1929, the eight years of the Small administration was succeeded by four years of the administration of Governor Louis L. Emmerson. Mr. Emmerson was a Republican, but the leader of the anti-Small faction of the party; with his advent to office came a much needed administrative housecleaning of Small appointees and practices.

The Department of Public Welfare, so urgently in need of rescue, received a competent Director in the person of Mr. Rodney

H. Brandon. Mr. Brandon had been campaign manager for the governor-elect, but was also an experienced administrator, having been for a number of years previously the capable manager of Mooseheart, a large children's institution near Chicago. To the important post of Superintendent of Charities, the Governor re-appointed Mr. A. L. Bowen, of previous valuable experience with the Department. Dr. Sidney G. Wilgus was appointed Alienist; Dr. Wilgus had served as Managing Officer of Elgin and Kankakee state hospitals under the Board of Administration, and for the intervening sixteen years had directed a private mental hospital at Rockford. A year later, also, Dr. Charles F. Read, former Alienist, returned to the state service as Managing Officer at Elgin, and continued as a valuable adviser. Hence the officers of the Department again became persons with interest and experience in its work.

Of the new administrative hierarchy, the Alienist was apparently the least secure, as reflected in his first report.

It was soon found that the State Psychopathic Institute hardly existed in form to justify the name, and that the duties of alienist had become indefinite and indistinct.¹

Duties of the Alienist Department

In the capacity of alienist it was my early endeavor to ascertain the exact field of my duties, but inasmuch as the Division of the Alienist had been through confusing conditions during the past 10 years, it was difficult to determine this. Finally a more successful attempt to explain these duties was made May 28, 1930, when General Order No. 255 was published by you. There still remain some adjustments even under this order, but I trust these can be made without difficulty.²

The indecision reflected above has some basis in the events of the previous administration. However, there were available to him the statements of his predecessors as to their duties, statements which were adequate at least for his temporary guidance. Moreover, General Order 255 carries the date of August 20, 1929, the date of his appointment. It sets out his duties in terms similar to those of the previous alienists and appears to

¹Department of Public Welfare, Annual Report, 1930, p. 25, Report of the Alienist.

²Ibid., p. 26.

be a useful guide to his program.¹ No explanation is offered for the conflict of dates as given by the Alienist. Nor, in view of the above General Order, is there apparent reason for his confusion about his duties. Certainly his professional area abounded in problems pressing for study and solution.

The task which faced the new administration was one for strong hands. The state institutions were now dangerously overcrowded--some 4,200 persons over their rated capacity. The first step was therefore to speed up the laggard building program to meet this need.

Hundreds were sleeping on floors, in overcrowded wards, and even in the hallways. . . . I am pleased to report that after 18 months of intensive building construction more than 8,000 additional beds have been provided for the institutions, or will soon be ready. . . . Of that total number of new beds, 4,800 are in the charitable institutions, principally at Manteno, Elgin, Dunning, and Lincoln.²

¹The text follows:

DEPARTMENT OF PUBLIC WELFARE

General Orders
No. 255

August 20th, 1929

Effective August 20, 1929

Sidney D. Wilgus, M.D. of Rockford, Illinois, is appointed Alienist of the Department of Public Welfare.

He shall act as chief medical adviser to the charitable group of institutions.

He shall devise and pursue policies concerning general or special medical treatment, care and after-care of patients.

He shall advise the schools of nursing, occupational therapy, and social service in the various institutions and advise the Superintendent of Charities on the size of staffs, transfer of physicians, etc., and shall direct the social service workers at the various institutions of the Division of Charities.

He shall act as director of the State Psychopathic Institute which shall include schools in psychiatric nursing, hydrotherapy and occupational therapy practice.

He shall act as liaison officer between the Department of Public Welfare and the schools of medicine, nurses, hospitals, physicians and all other societies whose interests touch the charitable institutions of the state.

(Signed) Brandon

²

Biennial Message of the Governor of Illinois to the State Legislature, 1931, Illinois House Journal, 1931, p. 27.

The congestion in the hospitals in the northern part of the state was more acute than downstate, due to the growth of the Chicago metropolitan area, and the greater complexity of living conditions within it. The Small administration had taken some steps toward a new hospital in the area; and appropriation was first recommended in the Governor's Message for 1925. Land was subsequently acquired at Manteno, and construction begun in 1928; the hospital received its first patients in 1930. For several years it housed only 900 patients, but was expanded to care for double that number by June, 1935.

The problem of adequate medical staff had never been faced; it continues with this administration. In his first report¹ the Alienist comments on the small number of the medical staff, the difficulty of holding men, and recommends a larger number, improved living arrangements, and decent professional tools in terms of libraries, laboratories, and proper equipment.

Among lower staff, too, morale was at a low ebb, and disorganization rife. Some clues as to the abuses which had grown up are supplied by the early General Orders² of the new Director, on taking office early in 1929. These were directed against the use of state institution buildings and grounds for political and social picnics, rallies, carnival and entertainments, to the detriment of the patients; the use of intoxicants by employees while on duty; the maintenance of families of employees by the institutions--many employees' families had been boarding at state expense. Other types of exploitation terminated included that of "equipping employees' cars with tires at state expense on the theory that the car has been used on state business," and the building up of institution inventories far beyond any immediate needs. The existence of these and other abuses in the state institutions is suggestive evidence of the extent to which administrative control had relaxed and morale declined.

Facing these and other problems the Emmerson administration was still in its first year of office when the depression

¹Department of Public Welfare, Annual Report, 1930, p. 26, Report of the Alienist.

²Department of Public Welfare, General Orders No. 245 and ff., 1929.

struck. Its immediate effects were favorable to the new program--prices of money, goods, and labor declined--a particular advantage for the large building program which was needed. With growing unemployment and lowering wage levels, employment in the state institutions became comparatively more attractive, and less difficulty was experienced in employing and retaining staff at both professional and attendant levels.

These changes were taken advantage of in the Department's program. In the years 1929 and 1930, 5,000 new beds were made available in the state institutions. It was the plan of the Department to continue its buildings program--a plan which was cut short by the tax crisis of the following years. Medical and nursing staffs were increased; attendant staff was increased and turnover somewhat reduced; training schools for nurses and for occupational therapists were established.¹

Since the economic situation was favorable, further advances might have been made in the Department. The backwash of the depression, however, sharply curtailed the expanding program. The state derived a considerable portion of its revenue from real property taxes in Chicago and Cook County. As the depression deepened, tax defaults increased to an alarming extent, so that both city and county revenues were seriously affected. The state, collecting a surtax on these same properties, suffered a marked decline in revenue, the low point coming in 1933. In the preceding biennium the declining revenues had forced the Department to cancel its building program; the appropriations were diverted to other uses. As a result of this financial crisis the Department was able to accomplish only a part of its intended program.²

The Psychiatric Institute.--A significant achievement of the Emmerson administration was the establishment of the Research and Educational Hospitals in Chicago. For many years there had

¹Biennial Message of the Governor of Illinois to the State Legislature, 1933, Illinois House Journal, 1933, p. 18.

²It is difficult to trace the detailed effects of the reduced appropriations on the Department, as annual reports are lacking for the period. As an "economy measure" no annual reports were published for the years 1932, 1933, 1934, and 1935. One report, published in 1935, purports to cover the four-year period, but actually relates more to the fiscal year 1934-35 than to the preceding years.

been a number of institutes and clinics affiliated with the College of Medicine of the University of Illinois, offering specialized services in different fields. The Department of Public Welfare had availed itself of these services for its wards, particularly in the field of ophthalmology and orthopedics. Moreover, in the Department, but functionally related to the teaching and research work of the University, were the Psychopathic Institute and the Institute for Juvenile Research, the former under the Alienist, the latter under the Criminologist. For more effective use of all these services it was desirable to unify them under a single administration. An informal agreement for this purpose had in fact been in effect since 1917, but it lacked definiteness because of the absence of legislative sanction.

The legal phase of the consolidation was achieved by legislation in 1931.¹ This Act drew together these various institutes and clinics and allowed for their unified administration by joint agreement between the Department and the state university. The agreement followed in March, 1932.² It provided for joint operation of the Hospitals; the joint selection of a managing officer and assistant, and in general for staffing and operation by the university. A joint administrative committee was set up to resolve any difficulties arising from the joint operation.

Of particular interest to this study are the provisions made for the Psychiatric Institute, one of the units of the Hospitals. Provision for research in mental diseases was not new in Illinois; it really began under the brilliant leadership of Dr. Adolf Meyer at Kankakee in the 1890's. With his resignation in 1895, research languished until revived under the impetus of the Deneen Board of Charities. In 1907, the Psychopathic Institute was founded for that purpose, and continues until the present. In the varying administrative fortunes of the Department, however, it has always been a stepchild, lacking consistent direction, with fluctuating appropriations, and moved about from one hospital to another. For the most part it had done routine laboratory exami-

¹Laws of 1931, p. 222.

²The agreement is set out in full in the Department of Public Welfare Report, 1932, 1933, 1934, 1935, pp. 405 ff.

nations for the hospitals; in recent years even this work has fallen off, as the downstate hospitals tended to use the newer and more convenient laboratory of the state Department of Health at Springfield. It has therefore become a routine service and abandoned the research function.

With the return of active administration of the Department under the Emmerson regime, steps were taken toward providing research facilities. An appropriation had been made under the Small administration for the erection of a building and equipment on the Chicago campus to be called the "Psychiatric Institute of the Research and Educational Hospitals." The building was completed in 1925, but due to the disorganization of the Department under the "Small" regime it was not occupied until February, 1932; its capacity of 62 beds has been fully utilized since that time. For admission of patients the Institute was considered a ward of Chicago State Hospital; most of its patients came from Cook County Psychopathic Hospital nearby.

From its opening day the Institute has engaged in an active program of therapy, teaching and research. The older name of "Psychopathic Institute" was dropped in favor of the newer term, "Psychiatric Institute." A competent, full-time staff is under the direction of Dr. Douglas S. Singer, Professor of Psychiatry of the University of Illinois College of Medicine, and (since 1932) state Alienist. New methods of therapy are tested and developed; training in general psychiatry given to students of the School of Medicine, and to a selected few appointees of the staffs of the state hospitals. Some instructional work is also done by the staff among the staffs of the state hospitals. The Institute has profited by wise and stable direction; it has gained a favorable reputation for its therapeutic methods and research work.

The Board of Welfare Commissioners.--An early act of the Emmerson administration was to revive the Board of Public Welfare Commissioners, nonexistent for the previous eight years. Mr. Willoughby Walling of Chicago, a member named by Governor Small, was reappointed and named chairman. The other members were: Judge Perry L. Persons of Waukegan (reappointed), Harry Lurie of Chicago, Rev. Frederick Seidenberg of Chicago, and Miss Mary Humphrey of Springfield. Some of these members were well equipped

for their task. The Chairman, Willoughby Walling, was a Chicago banker who had been active in the Chicago Council of Social Agencies; Mr. Lurie was director of the Jewish Charities of Chicago; Father Seidenberg was director of the Loyola School of Social Work; Miss Humphrey had been active in social and club work in and about Springfield. An appropriation of \$25,450 had been made for the Board for the biennium 1929-31, and was increased to \$27,130 for the succeeding biennium. A full time executive secretary was appointed in February, 1930, in the person of Mr. Frank Z. Glick, of the Chicago Council of Social Agencies. The stage appeared set for an effective revival of the Board's activity.

The revival, however, proved to be a limited one; its development was hampered by several early changes in personnel. Mr. Lurie resigned in 1930, having accepted a position in New York. His place was taken by Mr. Alfred C. Meyer, a retired business man and the able manager of Michael Reese Hospital in Chicago. In March, 1932, Mr. Glick was loaned full time to the Illinois Emergency Relief Commission, and resigned from the Board the next year. His work was carried on, and his office later filled by Mrs. Olive Hull Chandler, who had been a research worker for the Board and was well acquainted with the welfare topography of the state.

The Board took a broad view of its functions, as set out in an early report:

The present board was appointed in October, 1929. Its first work was a survey of its field of responsibility and the selection of specific activities in which it might helpfully engage within its statutory limits. The board is not administrative nor yet strictly advisory. While it does represent the public's interest in an effective administration of the state institutions and in the promotion of the well-being of the state wards, it is more basically concerned with the development of policies and standards, with the improvement of the methods of selection of personnel, and with the co-ordination of all welfare activities, local and state, public and private, to the end that not only may the state public welfare services be well administered but also that the general welfare shall be so safeguarded that need for the intervention of the state as custodian may be lessened.¹

The note of prevention was also stressed;

¹"Report of the Board of Public Welfare Commissioners for the Biennium 1931-1933" (Unpublished), p. 1.

The board deplores the fact that more than 95% of the state expenditures for public welfare service have perforce gone into institutional care for some 45,000 state wards. The more basic service, that of so encouraging and guiding community services and so utilizing available resources that commitment is rendered unnecessary, has had small part in the state program.¹

The Board continued its inspectional visits, but with a modified attitude: "The Commissioners have visited the various state institutions, not in the guise of inspectors of buildings and administrative routine, but in the attempt to sense the spirit and the adequacy of institutional service."² There is no record of the number of visits made nor of any specific action resulting from them.

The Chairman, Mr. Walling, had a particular interest in services for mental health. This interest, together with the assistance of the National Committee for Mental Hygiene, and local support by an advisory committee of Dr. Douglas Singer and Dr. Lewis P. Pollock, of Northwestern Medical School, was responsible for the preparation of a study and report entitled, The Effort for Mental Health in the State of Illinois, published in October, 1932. Preceding the study there had been an earlier exploratory conference of the Board with the deans of the medical schools in the Chicago area and officers of the Department--a conference looking to closer relationship between the medical schools (and the medical profession), the state hospitals and the Department.

The report is essentially a stocktaking document. It traces the development of the services for mental health in the state--departmental, educational, and those of social agencies, and in a loose way attempts to indicate their strengths, weaknesses, and needs. It makes no recommendations and outlines no program. Its "findings" are summed up in three statements relating to three areas of needed activity:³

1. The medical schools are in a position to exercise much more leadership than they have done in the past, in teaching and educational work in the field of mental health.

2. The mental hospitals, isolated in the past, must shed

¹Ibid., p. 2.

²Ibid., p. 1.

³The Effort for Mental Health in Illinois, p. 9.

their isolation and become centers of therapy and community education for mental health. Having the ultimate responsibility for the mentally ill, they must accept increasingly earlier and broader responsibilities for treatment.

3. The general hospitals at present refuse to care for mental patients. This refusal is a severe handicap in the total program--to the sick person who could profit by early treatment locally; to the physicians, internes, and nurses who could learn by treating these patients; to the community, which reflecting the attitudes of the other two, assumes that mental disorder is "something apart" and loses the strong educational force of demonstration for mental health. The general hospitals must accept the responsibility for treatment of mental patients.

The report is vague and incomplete at many essential points. However, in stressing the points mentioned above, it laid the basis of a co-operative relationship between the Department and the medical schools which was to be of value to both. It states the logic and basis of co-operation which was physically embodied this same year in the opening of the Psychiatric Institute. A specific result of the better understanding was the feeding into the state hospitals a larger number of recent graduates from the medical schools, as internes and junior physicians--staff of which the hospitals were in urgent need. On June 30, 1933, there were on the hospital staffs 52 junior physicians, compared with a low mark of 18 in 1930; there were also 10 internes, an increase of 5 since 1930.

Further progress of this development was evidenced in the following year, when in July, 1933, there was created by Governor Horner, the Illinois Psychiatric Research Council. The Council was a means of securing the co-operation of the other medical schools in the Chicago area; it was made up of a representative of each school, together with the state Alienist, the state Criminologist, and Mr. Walling. The organization of the Council was based on an agreement between the Department and each of the medical schools.¹ This agreement gave expression to the responsibilities of the Department and of the schools, as set out in the pre-

¹A full text of the agreement is given in the Report of the Alienist, 1932, 1933, 1934, 1935, p. 44.

ceding year.

The responsibilities of the Department for therapy, and of the medical schools for teaching, were stated to be complementary. Each had certain facilities, and in the mutual use of these facilities lay valuable opportunities for reciprocal assistance. It was therefore proposed that the medical schools furnish to the Department teaching at undergraduate, graduate, and post-graduate levels, relief from the "medical isolation" which had surrounded the state hospitals in the past, and assistance in research and civil service procedures for selection of staff. In turn, the Department proposed to offer its hospitals for internships for medical undergraduates and graduates, to provide teaching material in psychiatry for the schools, and to collaborate in research.

Specifically, the schools undertook immediately to provide an adequate curriculum in psychiatry, an out-patient service in psychiatry in their medical clinics, with provision for psychological and social services, and to develop, "as soon as possible," psychiatric in-patient service, graduate and post-graduate instruction and research in psychiatry, and competent psychiatric staff.

The reciprocal undertakings of the Department are of particular importance. The Department agreed to:

1. Bring up the standards of medical work in its hospitals to the requirements of the American Medical Association for the recognition of internes and residents as to records, staff-meetings, pathology conferences, laboratory facilities, X-ray equipment, and autopsies.

2. Select its medical staffs for hospitals, including Managing Officers and assistants, on a merit basis, and with proper respect for promotions and tenure.

3. Adopt the minimum standards laid down by the American Psychiatric Association for the operation of hospitals for mental diseases.

In 1933, the application of each of these points to the state hospital system would have required very extensive improvements. A "saving clause" was inserted, however, which recognized the Department's financial plight, and called for their full application "as soon as economically possible." This broad phrase

was not defined and allows much leeway--economic conditions appear to have been unsettled for a considerable period. To what extent they were achieved by 1938 was determined by an impartial study in that year; its findings are discussed in the following chapter.

Two other activities of the Board are worth mention.¹

The executive secretary made repeated efforts in the Department for an improved form in its annual reports, but without success at the time. His efforts may have been a contributing factor to the standard outline adopted by the Director in 1935, and circulated in that year to the Managing Officers for their guidance. The whole area of departmental information remains a stony and a brambly ground, as earlier noted.²

A more important and productive activity is the stimulation of the annual State Conference on Social Welfare. In this project, the Department and the Board have a large share--a share, however, which raises questions as to their relationship. The executive secretary of the Board is also executive secretary of the Conference; additionally, the Board supplies secretarial help, office space and supplies. The Department makes a large annual grant to the Conference, and publishes its reports. The Board justifies this use of its services by the reward reaped in using the Conference to promote welfare programs and legislation--often those which it has itself designed or aided. The Conference is a valuable mouthpiece and supporter--an interpretive vehicle of large value. For these returns, the Board gives this grant of salaries and services.

While the merits of this arrangement are apparent, some questions raised by it are also important and deserve consideration. They are, however, so related to the whole question of the place and function of the Board, and its relation to the Department, that they are left for later examination.³

¹Information from an interview with Mr. Frank Z. Glick, July 26, 1938.

²See Introduction, above, p.xviii. ³See below, pp. 66 f.

The Horner Administration

The election of 1932 returned a Democratic governor, Judge Henry Horner of Chicago, the first Democratic governor of Illinois for twenty years. In a state traditionally Republican, this upsurge of the Democratic Party had its patronage results throughout the state governmental machinery; the Department of Public Welfare did not escape.

The Director, Mr. Rodney Brandon, had proved a strong administrator, and had restored order and morale during his four years of office. There are indications that the governor-elect recognized his ability and would have been glad to retain his services. He had, however, the political disability of having been campaign manager of the preceding governor; regardless of his proven ability his political color was offensive to the new party, and his ouster was demanded. Soon after his "resignation" in August, 1933, the Governor appointed him as a member of the Board of Public Welfare Commissioners, so that his services were retained to the state at least in an advisory capacity.

His loss as Director was somewhat minimized by the immediate appointment of Mr. A. L. Bowen to that office. Mr. Bowen had had long experience in the Department, and filled the important post of Superintendent of Charities under Mr. Brandon. His advancement to the Directorship was in part a recognition of his experience and ability; in part a shrewd move by the Governor to fill the office with an executive with defensible experience, continuing the large administrative program under way, and at the same time ending political pressure for a Democratic appointee. That he was able to make this promotion despite Mr. Bowen's nominal Republican background is partially explained by Mr. Bowen's acknowledged familiarity with the complex affairs of the Department, and the non-political character of previous service; he was first of all a conscientious administrator.

The elevation of Mr. Bowen left vacant the office of Superintendent of Charities, an active and responsible post. This office remained vacant for five years, the Director carrying on its duties over his own desk. This vacancy was originally explained on the grounds of economy, in the biennium 1933-35, but in view of its importance this explanation is hardly applicable after that time--if, indeed, during it. The eventual elevation

of Mr. A. J. Brumleve to the post in September, 1938, changes the picture but little, as Mr. Brumleve already had his duties as Chief Clerk in the Department, and will hardly be able to take over the large and important responsibilities of the Superintendent of Charities additionally. Indeed, the whole question of Departmental organization is sharply raised at this point, as the picture presented is not a logical one of discharge of functions so much as a temporary answer to the question "Who can we put in here?" That the Departmental administration should be continued on such a temporizing and inadequate basis is cause for great concern; the problem is of prime importance and the subject of later discussion.¹

To the post of Alienist was appointed Dr. Douglas Singer, who had earlier filled the office under the Lowden administration. The appointment was a strong one. Dr. Singer was a psychiatrist of recognized ability; for years he had been Professor of Psychiatry at the University of Illinois College of Medicine. His early contributions to the Department were sound, and his return at this period of change and expansion was a fortunate one.

In the hospitals, the advent of the Democratic party was soon reflected in staff changes. Of the nine hospitals, seven had changes of managing officer during the Horner administration. Five of the seven were resignations and replacements by new heads; of these only two had had previous service with the hospitals. One managing officer died, to be replaced by a new appointee. The sixth, the aging Dr. Zeller, retired and his post was filled by promotion. There was only one hospital that did not change its managing officer during the period; two hospitals each had two changes.

The situation among assistant managing officers was worse. Of the nine hospitals, four had been without assistants for several years--two for four years, and two for one year. At the advent of the Horner regime, therefore, four of nine hospitals were without assistants. During the next four years these hospitals continued without assistants for varying periods--two for the whole four years, two for two years. A fifth hospital lacked an assistant for the last year of the period; at the end of it three

¹See below, p. 186.

hospitals were without assistants. Only three of the nine experienced no change during the period. Moreover, of the seven hospitals which had changes of managing officers during the period, four also had changes of assistant managing officers, and another was without an assistant managing officer at any time. The four-year period saw only one hospital (Elgin) which was secure with managing officer and assistant for its duration.

Insecurity was equally prevalent among the attendant staff. The staff turnover ratio, reduced to a previous low point of 1.33 in 1932, rose to 1.41, 1.65, and 1.73 in the years 1933, 1934, and 1935 respectively--the highest point of the preceding eight years. The explanation of this increased turnover lay not in the economic situation, which was basically unchanged, but in the flagrant use of patronage by the new administration. A new classification appears in the table on "Movement of Employees" in the Report of the Statistician--it is that of "Laid Off." In 1933, 1934, and 1935 there were 181, 339, and 262 employees respectively "laid off." These layoffs were plain political replacements--the employee was replaced by one in political favor, irrespective of the merit of either. It is significant, too, that the number of resignations increased sharply during the same period, from a 10 year low of 439 in 1932 to 489, 574, and 514 in the three succeeding years. The number given leave also doubled, from 502 in 1933 to 1,290 in 1935. In other words, wholesale replacements of hospital employees was in progress, under whatever name.

What effect this political staff upheaval at top and bottom alike had on the medical staff, laboring during the preceding four years to build up some sort of a trained staff--and with some success--is simply stated. The same turnover continued--a physician would come, work a few months, and resign. In the face of such a discouraging personnel situation, few cared to remain.

The Horner administration succeeded to power at the peak of the tax crisis. State revenues were frozen by the failure of tax payments; the state government faced a critical curtailment of all its activities. For the biennium 1933-35, the state budget was sharply reduced. For the Department of Public Welfare \$14,830,000 had been appropriated for the biennium 1929-31; \$12,750,000 for the biennium 1931-33. For the biennium 1933-35,

it was granted only \$10,100,000--the lowest amount in a decade, despite the steady increase of its responsibilities.

For the Department, this reduction meant a worsening of the already old story--more overcrowding, less staff, less therapy, lowered standards of care. Emergency buildings and repairs only were undertaken, and patients again slept in the corridors and on the floors. Physicians, nurses, and attendants were all overloaded, intensifying the already poor working conditions. To this strain was added the threat and confusion of the political staff changes. Small wonder that the turnover rate shot up, and that physicians and attendants alike preferred the uncertainty of employment in a depressed community to the pressure and confusion of an exploited hospital system.

The second biennium of the Horner administration brought some improvement. The tax situation had been eased and the state government's income increased. Funds for construction were available from PWA loans; WPA projects assisted in making needed repairs and improvements. In 1935, the legislature appropriated \$14,000,000 for a building program, to which was added some \$5,500,000 of PWA grants. The regular appropriation was also increased slightly--from the "economy budget" of \$10,100,000 of the preceding biennium to \$11,668,000--still an "economy budget" and much below the needs of the institutions. The building funds were devoted to additions and improvements to provide a total of more than 10,000 beds, "with the result that for the first time probably in the entire history of Illinois every one of its wards will have a bed and a decent standard of floor and air space."¹

The biennium also showed some stabilization in staff. Medical staff increased slightly, from a five year low of 111 in 1935, to 131 in 1937. The number of graduate and psychiatric nurses increased from 115 in 1933 to 140 in 1935 to 179 in 1937; the number of attendants also increased from 2,150 in 1933 to 2,403 in 1937. However, these increases in staff must be placed against a steady increase of patient population, from 25,870 in 1933 to 29,521 in 1937, a gain of 3,651 patients or the equivalent addition of another large hospital. Patient-staff ratios, there-

¹Biennial Message of the Governor of Illinois to the State Legislature, 1937, Illinois House Journal, 1937, p. 10.

fore, showed no improvement.

There were also indications of lessening political influence in personnel appointments, in that the number of layoffs decreased from 262 in 1935 to 70 in 1936 and 25 in 1937; resignations and leaves showed proportionate reduction, leaves dropping from 454 in 1935 to 112 in 1937. The turnover rate accordingly was reduced from the high of 1.73 in 1935 to 1.32 in 1936 and 1.22 in 1937. The low rate for 1937 reflected the relatively small number of additions and separations from the staff, 845 and 844 respectively--the lowest number in the history of the Department. Relative to the previous chaotic situation, therefore, personnel conditions showed distinct improvement. However, the absolute number of separations during the year 1936-37, 844 in an average payroll of 3,930, indicates that considerable employee unrest was still prevailing. Relatively, patient loads and working conditions were unchanged.

The Board of Public Welfare Commissioners.--The remaining work of the Board under the first Horner administration is a brief story.¹ Several changes in personnel occurred in the period. The term of Father Seidenberg expired in December, 1932, and Miss Agnes Van Driel, of the Loyola School of Social Work, was appointed in his place. The term of Judge Persons also expired at that time; no appointment was made in his place, with the result that for nearly two years the Board had only four members. Mr. Rodney Brandon, Director of the Department under the Emmerson administration, was appointed in September, 1934, restoring the Board to its full membership.

The "economy budget" of the biennium 1933-35 severely reduced the Board's appropriation; it was cut from the amount of \$27,130 for the preceding biennium to almost one-third of that amount, \$10,100. Such a drastic reduction forced the Board to a mere maintenance basis. Specifically, it allowed for the salaries of the executive secretary and one stenographer, with a small sum for office expenses. There was later added for travel expense a small supplementary amount (not to exceed \$1,000) from the Governor's contingency fund. The appropriation for the suc-

¹The Board's efforts in co-operation with the medical schools has been described earlier. See above, p. 53.

ceeding biennium was at the same level, an amount of \$10,700 being allowed. This skeleton appropriation permitted only of routine duties by the Board. Its reports for the period call attention to The Effort for Mental Health in the State of Illinois, the formation of the Illinois Psychiatric Research Council, and the subsequent development of an improved teaching curriculum in psychiatry in the medical schools.

Its interest was next directed toward the threatening eruption of political patronage in the state institutions. It correctly named this abuse as a demoralizing force, and one threatening the whole personnel basis of the Department. The Board strongly urged revision of the civil service law to check these abuses, to include the selection of Managing Officers of hospitals, and Superintendents of Divisions of the Department by civil service procedure. It called the attention of the State Conference on Social Welfare to these abuses, and through it, backed reform bills in the state legislature to this end. However party politics wanted no changes and the bills got nowhere in the legislature.

This very nominal activity of the Board, dictated by skeleton appropriations, sharply illustrates a second grave weakness in its powers. At the very time when departmental standards were lowered by budget cuts, and when patronage was riding roughshod over the merit system, the Board found its own hands tied and could make no effective protest. Its original supervisory and inspectional function was crippled, and it was forced to sit on the sidelines, aware of the disorganization in progress, but able to make only feeble protest about it. That it could be rendered so ineffective at a time of such acute need is a further indication of its grave limitations in carrying out its designated functions.

Summary

The first two decades of the care of the insane by the Department are marked by sharp contrasts--contrasts of economic situation, of administrative viewpoint, and of political motivation. The examination of these contrasts has been informing; the results can be summarized under two main topics--the political operation of the Department during the period, and a consideration

of its internal structure.

The whole period was marked by the political character of the administration. The Lowden regime is an exception to this statement; despite the chaotic economic conditions of that period, and the creaking of the new administrative machine, its direction was non-political. The administration of that period deserves large credit for establishing the working basis of the Department and remained the pattern for subsequent administrations. The eight years of Governor Small were blatantly political, from the lowest office to the highest; the resultant disorganization was frankly tragic. Against this disorganization the Emmerson administration made some headway; its period was marked by some constructive housecleaning and the restoration of morale at all levels of personnel. Much of its achievement in this direction, however, was swept away in the Horner regime. At the top, an uncertain stability was achieved by promotion to the directorship--uncertain, because other key offices were left vacant below. And among the hospital staff, open politicalization, in flagrant defiance of both civil service requirements and the morale so painfully built up through the preceding quadrennium, disgusted every conscientious employee. The inevitable result was again insecurity, uncertainty, staff turnover and wilted morale.

The reasons for this politicalization are familiar. The Director, being a member of the Governor's cabinet, was by political theory, necessarily a man whose political views and administrative policies were acceptable to the Governor--"someone who could work with him." That political views were secondary, however, is shown by the selection of directors under the Lowden and Horner administrations; the former was a business administrator without political color, the second a promotion of a proved administrator of opposite political stripe. More realistic was the frank use of the office as a political reward in the Small administration. This practice has applied to the post of Assistant Director in all administrations; as used by Small, however, it was extended to cover nearly all the executive posts in the Department.

The real volume of patronage, however, lies in the institution staffs. A department with 10,000 employees, most of them in positions with simple qualifications, is an inviting field for

the application of patronage. The promise and delivery of jobs is the lifeblood of any political machine. The Department supplied jobs in abundance, hence the party politician saw the institutions only as a gleaming opportunity for mass rewards. Against his avarice, the civil service law, the objections of department executives or managing officers, the protests of citizens' groups, all were minor obstacles; the tentacles of patronage early secured a firm grip on the Department and have yet to be shaken off. And the tentacles continue to suck the lifeblood of any competent administration--personnel morale. Without morale, the best executive intentions and the wisest administrative policies are negated. The supremely important link in the chain of therapy, that of attendant to the patient, is weak or nonexistent. Without it, therapy is a hollow mockery. Most of the history of the Department echoes this sad mockery.

To the political operation of the Department, too, can be laid much of the chronic overcrowding which prevailed during the period. The overcrowding resulted from the refusal of any given administration to face other than immediate needs; in a four-year period there was neither the opportunity nor the willingness to establish and carry out longtime plans. Plans made by one administration were disregarded by the next; it was no one's responsibility to give thought to the future. The present only was cared for--if that; decent long-time plans were not in the administrative picture.

Chronic overcrowding was the inevitable result of this hand-to-mouth living. The tragedy of this result was a viciousness of the whole circle engendered by this inherent irresponsibility. Overcrowding meant inefficiency and higher administrative costs, which again diluted the results from a given appropriation. And withal, of course, the impossibility of even decent care, let alone decent therapy, under such chronic circumstances, are well enough set out by the alienists themselves. The patient suffered--and the patient had no vote, few friends, and but feeble voice to make his suffering known.

A third resultant of short-term administration was the belated attention paid to research and public relations. Only in the last two administrations has activity commenced in these directions, and this activity was a product of the Board rather

than the administration. The two decades since the World War were rich in medical and psychiatric discoveries; their application to mental disease was essential to proper therapy. Yet in Illinois, the state hospital system continued on a custodial basis almost to the end of the period, with an occasional nod to the progress of therapy outside. Again, it was no one's responsibility to promote such developments--an administration living for the day had no interest for such "frills." And so the tragic isolation of the hospitals was perpetuated for years after it had begun to break down in other states and countries--isolation both professional and institutional; the state hospitals were gaunt "places apart" of which the medical profession and the public knew little and cared less--tragic eddies in the onflowing stream of psychiatric progress.

These tragic but inherent results of politicalization were more widespread than in any earlier period of state care. Previous to 1910, the hospitals had had their separate administration, and political influences, where present, were localized. Under the Board of Administration, civil service practices were observed; administration was continuous, responsible, and of good quality. The consolidation of all welfare activities and institutions under the Department had large potentialities for good or bad results--good, when administrators were competent the many branches of the Department benefited by the accompanying stability and progress; bad, when patronage was in control, its effects were so pervasive and so widespread that the resulting damage was irreparable. The actions of the Small administration were not only tragic at the time and in the periods immediately succeeding, but they gave the young department such a twist and set in its political outlook that each succeeding administration was tempted to continue such tactics and to justify itself by past history and precedent.

The lesson from this experience is simply stated; its application is more difficult. The care of the insane, as an accepted state responsibility, must be rid of political exploitation. In assuming guardianship of these broken and anxious people, the state assumes a solemn professional responsibility--the responsibility of providing such care and therapy as will restore the patient to his useful place in the community as quickly as

possible. The proper discharge of this responsibility is of mutual benefit to all parties--the patient, in his return to health and earning power; his family, in release from anxiety and return to normal income and living conditions. The community (local and state) benefits doubly--first in the restoration of a participating member, with the return of his economic and social contributions; the state, having minimized his period of incapacity and institutionalization, has been saved the double expense of prolonged and costly institutionalization, and in many cases the granting of assistance to maintain his family during his absence.

The proper discharge of this serious responsibility by the state requires the best type of administrator and his most effective functioning. There is no single place in it for political viewpoint or patronage consideration. It is an expert, professional job that calls for the best efforts of trained administrator, physician, nurse and attendant. That job will never be well done until political patronage is completely ruled out in viewpoint and practice; public health organization has no place for it.

The foregoing account of the Department also indicates a number of structural weaknesses which impaired its functioning. Prominent among these are the lack of definition of function of the executive officers, or the requirement of qualifications for them; the isolated and ineffective position of the Alienist; the weakness of the Board of Welfare Commissioners; and more recently, the impossibly large size of the Department as the responsibility of a single administrator.

The Civil Administrative Code named the officers of the Department and their salaries; it said nothing about their duties or their qualifications for these important posts; it did not even require that the offices be filled. As a result, the Governor was free to appoint whom he wished to any office, irrespective of the appointee's interest, training or experience--even to the important posts of Director and Alienist. Or, any post could be left vacant, as he saw fit, irrespective of the resulting damage to the work of the Department. When appointed, no officer had any official statement of his duties and responsibilities. Under the better administrations these duties were defined by administrative order; when other administrations failed to do so,

ignorance, confusion and irresponsibility resulted. In contrast, the qualification for the several grades of medical officers (exclusive of managing officers) were specified by civil service; they were selected on a merit basis. Plainly apparent is the irony of selecting lower staff on merit basis while disregarding merit principles for executive staff. The inevitable result was a feeling of injustice, insecurity and dissatisfaction on the part of the merit-selected staff--a natural disgruntlement which was in evidence throughout the whole period, and was fatal to the building up of morale or the rendering of efficient service.

The position of the Alienist in the Department has been a curious and ineffective one--an advisory person, without qualifications, status, responsibilities, or power. It is not surprising that such a vaguely defined office ordinarily drew incumbents of nominal ability; the exception to this practice occurred in those strong administrations which valued sound psychiatric advice, and in which the appointee thereby had assurance that his opinion would be both respected and enforced. For the rest of the time the office suffered varied fortunes; it went vacant for several years; it was filled for a period by a promoted officer, conscientious in his purpose and work but whose resignation was finally submitted because even his most elementary recommendations went disregarded; it was filled at other times by physicians of nominal attainments whose influence was negligible.

The advisory function of the Alienist in the Department is frankly ironical. The spectacle of a public health service, charged with the care and therapy of 30,000 mentally ill persons, housed in ten large hospitals, having only advisory psychiatric service for its direction is almost unthinkable were it not true. And in Illinois, even though that adviser be a competent and skillful psychiatrist, his efforts are effective only to the degree that the lay administration agree with them and translate them into practice, against such obstacles as limited appropriations and politically-appointed staff. Small wonder that therapy has languished and that the record shows a drab repetition of overcrowded mass custody--the continuation of nineteenth century outlook in a twentieth century of new knowledge and therapeutic practices. For the most part, in 1937, these had yet to penetrate the brick walls of the Illinois institutions.

The Board of Public Welfare Commissioners, likewise occupies a situation in the Department which is potentially ineffective. The Deneen Board of Charities made a distinguished contribution as the Board of State Charities and under the Board of Administration; its services and reputation were still too fresh in 1917 for the omission of its inspectional function; that was continued by the Board under the Department. Under the reorganized administrative powers of the Department, however, the need for it was much reduced. The departmental form of state administration centered the administrative power in the Director, responsible to the Governor. To that post the Governor would not appoint an executive who did not hold his confidence and respect; he would therefore feel no need for inspectional reports by another branch of the Department, perhaps less well equipped to evaluate administrative processes and results than the Director himself.

Such a development occurred in the first administration. The Board of Public Welfare Commissioners at first attempted inspection of the Department's institutions; these visits, however, were soon turned over to the Department, and eventually became a logical part of routine administrative work. The Director and other officers knew more about the Department's work than did the Board; they had its confidence, so it soon found its work unnecessary and drifted into inaction. This trend was hastened by the action of the Department in taking over the other function assigned the Board, that of statistical reporting. A basic part of administrative process, the gathering and preparation of statistics, was a function properly belonging to the Department and not to the Board. The Board, therefore, was left with little to do.

So little, in fact, that the succeeding administration saw no use for it and suspended its work altogether. When revived, eight years later, it largely abandoned its inspectional function, and set its purpose as an advisory one on matters of state public welfare concern. In this broader field there was much to be done, as the recent constructive activities of the Board indicate.

The inherent weakness of the Board's position in the Department has been indicated; it is worth restating. First and most important, it is dependent on the Governor's willingness to create it by appointment and permit it to function by providing

appropriations. Second, its budget is part of the Departmental budget; if the Director is hostile to it he can render it ineffective by eliminating or reducing its budget. Being thus dependent on the Governor and on the Director of the Department, the Board is in no position to be critical of either; faced by important issues it has no independence and no effective powers. Also, when most needed for advisory work it may be nonexistent or limited by reduced appropriations. In view of this inherently weak position it is not surprising that its work under the Department has been sporadic and ineffective. Its advisory function, recently reclaimed, is worthier of a stronger framework; the possibilities of such a framework are later discussed.¹

This discussion has examined the loose organization of the Department, the isolation of the Alienist, and the weakness of the Board of Welfare Commissioners. Complicating these and other factors has been the large size of the Department, with its varied responsibilities. The size and range of these responsibilities would have taxed the most efficiently organized Department; the present Department, with its inherent weaknesses, has staggered increasingly under the load.

When created in 1917, the Department took over the work of the Board of Administration, operating the charitable institutions; the operation of the prisons, reformatories, and parole services, and the state child welfare services and institutions; for the first time these varied services were administered under a single Director. In the preceding planning, serious thought had been given to segregating the correctional work in a separate department, since it had never been under the Board of Administration, appeared less related to welfare services than did the care of the insane and the child welfare activities, and was so separated in such other states as New York and Massachusetts. The decision, however, was to include the penal institutions in the Department; these were to be directed by the Superintendent of Prisons, the Superintendent of Pardons and Paroles, and the Criminologist.

Even in 1917, the resulting responsibility was a heavy one. The new Department operated eight large state hospitals,

¹See below, p. 190.

with 18,000 patients and 2,000 employees; three reformatories and prisons with 5,000 prisoners and 350 employees; five child welfare institutions, and various other services of inspection, visitation, and deportation. Its appropriation for its first biennium was \$8,412,000, several times that of the next largest department, and nearly as much as the total operating funds of all other departments combined. Thus, from the beginning, the Department demanded larger administrative effort than any other department on the basis of size alone.

Through the years its loads increased steadily--more hospitals, more prisons, more activities in every branch. In the last few years, the advent of the federal social security program added further new responsibilities, particularly in old age assistance and child welfare services.¹

By 1937, the total number of persons under care of the Department (exclusive of old age assistance) had grown to 40,000; it operated 27 large institutions of varied kinds; its employees numbered some 10,000 persons. Its newest activity alone, that of old age assistance,² started in 1936, had grown in two years to have some 900 employees caring for 115,500 pensioners, and disbursing \$17,000,000 annually.

While this mere physical growth is impressive, the administrative problems increased with even greater rapidity. During the life of the Department no field of public administration has undergone such striking and rapid changes as has public welfare. The field of medicine, psychiatry, penology, and social work, have each made important advances; their combined contribution has changed the current practice of public welfare administration to a remarkable degree. To profit by these advances new outlooks, new personnel and new methods are necessary; the new wine of public welfare administration cannot be contained in the old bottles of charities and corrections.

The Illinois Department has been so involved in trying to keep pace with its physical growth that it has had little time

¹Illinois has not yet adopted the federal plans for Aid to Dependent Children nor Aid to the Blind. If and when it does so these will add large new responsibilities to the Department.

²As reorganized at federal insistence in 1937.

or attention for these newer developments. The handicaps of its internal weaknesses, its under-staffing, the political influences and limited appropriations, have prevented its growth as an efficient administrative unit. The past few years have seen serious breakdowns of its machinery in the administration of old age assistance. There is therefore urgent need of a thorough reconsideration of its whole organization in the light of its present and future responsibilities. Such a reconsideration is attempted in our final chapter.

CHAPTER III

THE HOSPITALS

The Department's activities for the care of the mentally ill are expressed almost wholly through the state hospitals. Little preventative work is undertaken, nor are any clinics operated by the hospitals for early diagnosis or treatment of mental illness. Research work is extremely limited in quantity and scope. The parole clinics, whether held in the hospital or the community, are an extension of hospital services serving only its previous patients, and staffed by hospital staff. The hospitals therefore represent the Department's whole effort in this field.

The growth of the hospitals to their present size is shown in Table 1. Table 2 gives some basic data for each hospital. The period has seen the addition of only one new hospital,

TABLE 1

GROWTH OF ILLINOIS STATE HOSPITALS (Figures for Fiscal Year ending June 30)

Year	Number of Hospitals	Number of Patients	Value of Real Property
1938.....	9	30,234	\$.....
1937.....	9	28,393	33,166,000
1936.....	9	27,451	26,391,000
1935.....	9	26,572	25,785,000
1934.....	9	25,963	23,532,000
1933.....	9	25,226	23,534,000
1932.....	9	24,240	24,099,000
1931.....	9	23,515	23,849,000
1930.....	8	22,786	18,935,000
1929.....	8	21,869	18,094,000
1928.....	8	21,402	17,091,000
1927.....	8	20,804	16,466,000
1926.....	8	20,650	16,022,000
1925.....	8	20,285	15,563,000
1924.....	8	19,656	15,345,000
1923.....	8	19,050	14,707,000
1922.....	8	18,757	14,941,000
1921.....	8	17,912	.....
1920.....	8	17,098	.....
1919.....	8	17,886	.....
1918.....	8	18,264	.....

TABLE 2
THE STATE HOSPITALS OF ILLINOIS
(June 30, 1937)

Hospitals	Date of Opening	Value of Real Property	Number of Patients
All hospitals....		\$33,166,000	28,393
Alton.....	1914	1,402,000	1,496
Anna.....	1873	1,550,000	2,276
Chicago.....	1912	3,723,000	4,892
East Moline.....	1898	1,717,000	2,155
Elgin.....	1872	5,217,000	4,939
Jacksonville.....	1849	2,251,000	3,276
Kankakee.....	1877	3,079,000	4,240
Manteno.....	1930	7,724,000	3,253
Peoria.....	1902	1,595,000	2,597

Manteno, opened in 1931. This modern institution, situated thirty miles south of Chicago, has increased rapidly in population due to transfers from other hospitals and the recent diversion to it of most of the new patients from Cook County. The older hospitals, founded at various times since 1849, have been enlarged by the addition of new buildings to care for the steadily mounting patient load. It will be noted that the number of patients has nearly doubled during the period, 1917-1937, and the state's investment in its hospitals has more than doubled between 1922 and 1937.

The older hospitals were built in the then-standard congregate style. The "main building" was a large, congregate block, with offices and services in the central portion, flanked by extended wings containing the wards, men on one side and women on the other. Jacksonville, Elgin, Anna, East Moline and Peoria have large original buildings of this type, though their newer buildings tend to follow the cottage plan. Kankakee, erected in 1877, was a break from the congregate plan, and marked the beginning of the cottage plan in Illinois hospitals.¹ Chicago State Hospital, taken over from Cook County in 1912, consisted of several large congregate units. The congregate plan has unfortunately been perpetuated at this hospital by the erection in 1937

¹See Burke, *op. cit.*, p. 236.

of a new main building to house 900 patients in a single block of dormitories. Alton, built in 1914, substituted several smaller buildings for the large central block. The newest hospital, Manteno, was well planned on the cottage plan, and allows for expansion by the addition of cottages of harmonizing size and architecture.

Offsetting some of the custodial appearance of the large congregate buildings are the newer cottages at most of the institutions. The term "cottage," as used by the Department in relation to the state hospitals, refers to a ward building of smaller size. It is one story only, at ground level, contains from two to four wards, and houses from one to two hundred patients. They are of attractive, fireproof construction, economically built, and lend themselves well to patient classification. These cottage units are now a standard device for hospital expansion. Because of their attractiveness and utility, the Department deserves credit for their utilization.

Among the hospitals, plant is only one feature to show large variations. Marked differences exist in almost all phases of operation; some of these variations are set out in Table 3 below. The table is a summary of certain administrative ratios for the different hospitals. The most stable factor is seen to be the cost of care, which varies only slightly between the hospitals, as the relative costs of its main ingredients--shelter, food, and supervision, are uniform over the state. Other ratios, however, show large variation.

Staff ratios vary widely. The average number of patients for each physician for all hospitals is 260; the lowest hospital has only 194, the highest, 340; the highest hospital is 130 per cent of the average rate, and 175 per cent of the lowest rate. Graduate nurses and attendants show an even wider range of variation. For graduate nurses, all hospitals show 248 patients per nurse. But the lowest hospital has only 90, the highest hospital 314, or 3 1/2 times as many patients per nurse as the lowest hospital. Less disparity is shown with attendants, but even here the highest hospital has 1.75 times as many patients per attendant as has the lowest hospital. The use of social workers likewise shows marked variation, the highest hospital having more than three times as many patients per social worker as the lowest

TABLE 3

STAFF--PATIENT RATIOS
BY HOSPITALS
(JUNE 30, 1937)

Hospital	Number of Patients Present	Number of Patients for Each:				Per Cent of Patients on Parole	Per Capita Cost of Care (Disburse- ment)
		Physician (Including Managing Officers)	Graduate or Psychiatric Nurse	Attendant	Social Worker		
All hospitals	28,024	260	248	11.4	1,750	3.40	\$248
Alton.....	1,446	290	242	8.1	1,446	3.07	259
Anna.....	2,192	274	137	9.7	2,192	3.30	231
Chicago.....	4,723	249	278	14.1	1,181	3.05	226
East Moline....	2,017	253	156	9.5	2,017	5.85	243
Elgin.....	4,653	194	245	12.1	1,551	5.36	228
Jacksonville...	3,211	291	119	13.8	3,211	1.95	249
Kankakee.....	4,073	340	314	11.9	4,073	3.32	249
Manteno.....	3,189	319	123	10.1	1,595	1.60	233
Peoria.....	2,520	229	90	11.6	1,260	2.81	230

hospital.

The percentage of patients on parole also varies greatly from lows of 1.60 and 1.95 per cent at Manteno and Jacksonville to highs of 5.36 and 5.85 per cent at Elgin and East Moline; the highs are three times the lows. The use of parole is merely another reflection of the variations of policy and practice among the different hospitals. Despite its marked advantages, the average use is far below the maximum use, and two of the largest hospitals make only indifferent use of it.

This evidence indicates wide variation in the standards and practices of the hospitals. These variations are to be explained by a number of factors--among others the ability and interest of the managing officer, the calibre of his professional staff, and the location of the hospital in the state. The variations mean, however, that the quality of care received by patients in one hospital may be below the "average" of care for the state, and far below the standards achieved in the best hospitals. The "accident of geography" may determine whether a patient receives good care or indifferent care, despite the fact that all have paid equal taxes and have equal claim to the best treatment the state can provide.

Responsibility for this wide variation in treatment levels lies squarely at the door of the Department and the Director. It is certainly the responsibility of the executive to see that essential minimums obtain in all hospitals, and that the helpless wards of the state under his care are afforded equal opportunity for proper treatment and recovery. These equal opportunities have not been afforded in Illinois, and the reasons for this administrative failure have been set out in the preceding sections. The administrative structure of the Department is so unwieldy and the volume of work so large, that no Director, under the present plan, can secure effective results. This initial difficulty is worsened by the separation of administrative and professional responsibilities, and aggravated by the fact that the past and present administrators charged with these heavy responsibilities have been persons without any particular fitness or training for the post. It is not surprising, therefore, that gross inequalities have developed, and that most of the patients under the state's guardianship receive care far below the standards of that obtainable in

the State's best hospitals. Unfortunately, any leveling which has been done has tended downward toward mediocre standards of care rather than upward toward the standards demonstrated as obtainable in the best hospitals.¹

Happily, an evaluation of the several hospitals is available from a competent source. In 1933, a small committee of the Institute of Medicine of Chicago made a brief evaluation of the hospitals² at the request of the (then) Director, Mr. Rodney Brandon; the Board of Welfare Commissioners, under Mr. Willoughby Walling, was an actively interested party to the study. This evaluation made a number of important findings, to which later reference is made. Because of its limitations, one of the chief needs it noted was for a more comprehensive and detailed survey of the hospitals and their operations, and such a survey was recommended. This careful study was undertaken by the Institute in 1938, on the request of the Governor and the Director, Mr. A. L. Bowen. The results were set out in a report³ issued in August, 1939. The study covered not only the mental hospitals, but the institutions for the feeble-minded at Dixon and Lincoln and the other state institutions for children and the handicapped.

These two studies, six years apart in time, both indicate the variation in quality of services referred to above. Both found a large spread in the number and qualifications of managing officers and medical staff, and in the professional facilities available in the various hospitals. The conclusions of the

¹Since these comments were made the situation has been improved at some points. On February 1, 1940, the Director created within the Department a Division of Mental Hospitals, headed by a Superintendent. The Superintendent was given the function of medical direction of the State hospital service. A Supervisor of In-Training (Nursing Adviser) was also appointed at this time. These improvements follow the Report and Recommendations of the study made by the Chicago Institute of Medicine. See pp. 75 ff. It is significant that the authority of the Superintendent is still limited to medical affairs. The broader aspects of administration remain in untrained hands.

²Committee of the Board of Governors of the Institute of Medicine of Chicago, Illinois State Hospitals for Mental Diseases (November, 1933).

³Committee of the Board of Governors of the Institute of Medicine of Chicago, Medical Services in the State Charitable Institutions of Illinois (June, 1939).

earlier report set out the situation and emphasized certain features. There was insufficient medical staff; the existing staff included many older physicians who lacked both psychiatric training and merit appointment. The hospitals' equipment and practices were substandard; housing facilities for staff were inadequate. The hospital staff were found to be isolated from their professional communities. Related recommendations called for strengthening the Department's structure, rigorous application of merit system practices, and improvement of professional standards and community relationships.¹

The later study was much more comprehensive and detailed, and its findings are therefore of direct interest, appraising as it does the hospitals at the end of the period here under review. In part, the variability of the services in the hospitals was laid to the fitness of the managing officers, as follows:

The variability in the kind and quality of training and in fitness for the position of managing officer of a state hospital or school for the feeble-minded is great among the present incumbents. Although 7 of the 11 have held previous appointments to junior ranks in Illinois state hospitals, many do not give evidence of that degree of superiority and special training so necessary for this important position. Furthermore, some have had so little training or experience in neuropsychiatry that it is not strange that medical leadership does not exist in their institutions.

From the standpoint of care of grounds and buildings, housing, cleanliness, and feeding of their patients, on the contrary, all manage quite well. Their understanding of defects in these matters is good and they attempt to remedy such defects. As to the management of general medical and surgical care, their viewpoints and interest vary considerably. Generally they evince too great a tendency to approve a custodial routine in this respect.

As to active treatment programs and clinical and pathological investigative work, there is generally a lack of suitable preparation to supervise or encourage such work, a failure to recognize fully its value as a means of improving the state hospital service, or a hopelessness as to undertaking it effectively under present circumstances.

The lack of security which now attaches to the position of managing officer undoubtedly makes it difficult to obtain men with suitable qualifications. Six of the 7 who came up through the ranks have relinquished their civil service status. The seventh, in order to retain his civil service status as assistant managing officer, is acting managing officer only. It should be possible to recognize ability, qualifications, and service by promotion to this the highest and most

¹Ibid., p. 34.

important position in institutional medical service without requiring that security of tenure be forfeited.

A managing officer needs to have, in addition to proper training, a scientific viewpoint, energy and initiative, and such reputation and prestige that he can secure what is necessary to build up his institution. Only a thoroughly qualified man, imbued with a deep love of his work, and willing to sacrifice the other rewards his qualifications should allow him to achieve, would be willing to become a managing officer under present conditions. Rarely can such a man be found. This survey revealed only 1 managing officer who has been able to do a great deal and 2 or 3 who have possibilities.¹

The general findings of the Institute's Committee can be summed up under the topics of the strengths and weaknesses of the hospital services, the general care of patients, social service, and recommendations.

The Committee was impressed by the progress made in housing since 1933, and had praise for the new diagnostic units at several of the hospitals. It noted that the building program had eliminated overcrowding in general, though it continued in certain wards of some hospitals. The receiving services in general were well conducted, having good buildings, staff and therapeutic facilities; however there was marked disparity in some hospitals between the quality of care provided in the receiving unit and that available on the other wards. The use of newer therapies, particularly insulin and metrazol, was general and well conducted. The quality of food served the patients was good, but the service of it was often unattractive.

With reference to the executive control in the Department, the study pointed out the weak and ineffective position of the Alienist, and the overlapping of the Psychopathic Institute and the (newer) Psychiatric Institute. It also pointed out the detachment of the two large training schools for the feebleminded, since they come neither under the Alienist nor the Criminologist, and have suffered professionally as a result.

Within the hospitals, it noted the large variation in the qualification and ability of managing officers, and weakness of medical staff in numbers, qualifications, salary, housing and professional opportunities. Deficiencies were found in professional equipment such as clinical and pathological laboratories, X-ray

¹Ibid., p. 8.

and dental services, pharmacies and libraries. With reference to therapies, they found recreational and occupational therapy well developed, as was hydrotherapy; physiotherapy, however, was inadequate.

An important comment was made with respect to the use of work about the institution as therapy, as follows:

In all institutions opportunities for the employment of patients were abundant if not overabundant. Patients worked far in excess of the amount required for therapy. It should be recognized that work by patients beyond the amount necessary for therapeutic purposes is a contribution by them to the cost of their care. That all work assignments should be made primarily for therapeutic reasons, with the patient's welfare rather than institutional needs in mind, goes without saying.¹

It is significant that this exploitation of patients by the state, in order to keep down maintenance costs, came clearly to the attention of the Committee. Its important relationship to parole and discharge is developed later in the present study.²

The survey committee was concerned about the physical health of the patients in several hospitals. While their health was generally good, serious conditions of dysentery were found in two institutions, and tuberculosis was so widespread as to be a grave concern. Particularly serious in the latter disease was the fact that the patients were contracting tuberculosis after their admission to the institutions, a serious commentary on the standards of hygiene prevailing. At another hospital failure to conduct routine prophylaxis against typhoid and smallpox alarmed the committee which urged that these preventive measures be taken immediately.³

The general care of patients was found to approximate the custodial level, with exceptions in the admission services and in

¹Ibid., p. 42.

²See below, p. 115.

³This timely warning went unheeded, however, and tragedy struck a few weeks later in the form of a typhoid epidemic which took the lives of 53 patients before being brought under control. While the responsibility for this tragedy can be technically placed on one or another official, the real cause lies in the low standards of care in the hospital, coupled with the impossibility of proper supervision by a lay Director, harassed by his multitudinous duties in this omnibus department.

a few better managed hospitals. Less overcrowding was evidenced in 1938 than in 1933, though certain wards were still overcrowded. The food was generally of good quality, but often unattractive in preparation and service, so that it was not palatable and properly relished; part of the cause for this condition lay in the lack of competent dietitians to direct its preparation. The patients' clothing showed good variety, and the operation of beauty parlors in several of the hospitals tended to improve the appearance and morale of women patients.

The quality of care received from the attendants can be estimated in terms of the attendants' qualifications. The Committee found that of 2,669 attendants in service on June 30, 1938, only one in three had attended or completed high school, and only one in twenty had any nursing training. Such low qualifications help to explain the lack of any training courses, and reflect seriously on the quality of care that such a group, of limited education and more limited training, could render to the helpless wards of the state.

The problem of high turnover of attendant staff was examined in detail, with the following conclusion:

The method of selection and appointment is evidently poor and thoroughly unsatisfactory both from the employer's and the employee's standpoint. The security of tenure desirable in a job for which one qualifies is absent. The high number of resignations emphasizes again that from the employee's side something is wrong.¹

With respect to the Social Service Department, the Committee's findings are of interest. It found that the present staff was struggling under a great volume of work, with urgent need for more workers; despite the increasing load, however, the quality of work had improved due to the use of more trained workers. There was need for a better salary scale, and particularly for opportunities for promotion and advancement within the service. The lack of social service at Lincoln and Dixon was deplored, and an immediate provision of this service recommended.

The recommendations of the Institute's Committee follow closely their findings given above. In brief, they called for a competent medical director for the state hospital service; in-

¹Medical Services in the State Charitable Institutions of Illinois, p. 48.

clusion of managing officers under civil service, with proper qualifications; increases in number, salary and qualifications of medical officers, nurses and attendants, and the ending of political methods of appointment; expansion of the resident and consultant medical staff and increased provision of clinical and therapeutic services; increased social service staff and parole clinics. The similarity between these findings and recommendations and those of the present study are apparent. That two studies of the care of the mentally ill in Illinois, made by different investigators from widely different approaches and using different methods, should so closely agree on findings and needs is surely no accident. The needs, their causes and their remedies, are plain. It is to be hoped that the remedies called for will be promptly applied.

CHAPTER IV

THE INSTITUTIONAL PERSONNEL

It is a truism in administrative work that the quality of performance depends directly upon the quality of the personnel. In the field of mental hospital administration the principle has particular application; here the standards of physical care are dependent on both personnel and equipment. In the hospital's large use of psychotherapy, however, the need for competent personnel is of compelling importance. And this is true at all levels of therapy, from the skillful diagnostician down the scale to the humblest attendant. Here, indeed, the chain is no stronger than its weakest link. The best diagnosis and plan of treatment is useless without attendants capable of translating it into action.

Indeed, not only may inaction result but the poor attendant has a more sinister influence. In primary contact with the patient, his ignorance or lack of interest may bring direct harm to the patient, or affect the patient adversely by his failure to report significant points to the physician. And beyond this passive inaction lies the darker area of carelessness, hostility, and sadism, the outcroppings of which have left dark stains on many a hospital administration. Positive therapy, therefore, is dependent on qualified personnel at every point. The first chapter of this study included a discussion of the Department personnel at its executive level. Because of its importance, further attention is paid here to the hospital personnel--the keystone in the arch of therapy.

The principle of selection of hospital employees by merit had general acceptance in Illinois in the earlier period prior to 1893. In the Altgeld administration of that year and those of Governors Tanner and Yates who followed him, patronage flared up throughout the state services. The civil service reform movement had been gaining impetus across the country, and these eruptions of patronage in Illinois heightened local interest and energized

efforts for reform. Both political parties declared themselves in favor of the merit principle, and after several years of effort, the first Civil Service law was enacted in 1905.¹ This law applied only to subordinate employees in state institutions, but did mark the acceptance of the principle in state government.

With the establishment of the Board of Administration in 1909, all the employees of the Board and those of the State Charities Commission came under the Act. The Board and the Commission were both active in support of the Act, and in promoting its extension. The general drive for its extension also continued and resulted in 1911 in an amendment² which broadened its application to include most of the positions and offices in the state service; some 80 per cent of the total employees were now covered. For the hospitals, the only office exempted was that of managing officer; all other employees came under the law.

The original acts gave the state a workable merit system. It was administered by the State Civil Service Commission, a bipartisan commission of three members, with executive secretary and staff. The principles of merit selection, promotion and hearing on discharge were contained in the original acts. Despite certain important exemptions it appeared that substantial observance of the merit principle had been secured.

For several years administration went smoothly. During these years the centre of interest in the state government shifted from civil service to reorganization of the state services. The foes of civil service were content to bide their time; the shift of attention from the law to other areas was to their advantage and they had not long to wait before striking a crippling blow. The departmentalization of the state government in 1917 left the Civil Service Act untouched. But another move in that same year opened a wide breach in the Act; it was the so-called Buck Amendment.³

The basic principles of sound civil service are appointment on the merit basis, and removal only for cause, with right of hearing. The Buck amendment scuttled this latter provision by

¹An Act to regulate the Civil Service of the State of Illinois, Laws of 1905, p. 113.

²Laws of 1911, p. 222.

³Laws of 1917, p. 289.

providing for removals for "just cause"--just cause being any cause detrimental to the public service other than reason of politics, race, or religion. In one sweep, therefore, the security of the appointee's tenure was abolished. Any employee could be dismissed by the appointing officer "for the good of the service." This dismissal was not reviewable by the Commission unless the employee could allege discrimination on political, racial, or religious grounds. The burden of proof was then on the employee to substantiate these grounds, an almost impossibly difficult task in the face of a vague, general charge. Moreover, on the employee was placed the responsibility of filing his statement and appearing at the hearing before the Commission, usually at Springfield, at his own expense. The difficulties of this procedure, coupled with the small chance of proving his point, actually deprived the employee of any real appeal. Arbitrary action by appointing officers could therefore go unchallenged.

Other changes were made in the law under the stress of war conditions. Under an amendment of 1919¹ provision was made for temporary appointments with examination, for thirty day periods but renewable, and for temporary appointments where no eligible list had been established. Originally made because of the scarcity of employees during the war period, these amendments remained in the law, and offered easy loopholes for appointments outside the service, and for continuing those appointments. Further, a rule² on suspensions adopted by the Commission allowed an appointing officer, subject to approval by the Commission, to suspend an employee for thirty days, without pay, for disciplinary reasons; such suspension was also renewable. These extensions of arbitrary power, applied by successive political machines, soon resulted in the scuttling of the merit system throughout the hospital service.

For attendants, the processes of selection and employment were also politically directed. Under the law³ the Commission was given discretion in the methods of selection of laborers,

¹Laws of 1919, p. 292.

²Rules of 1934, Rule VI, sec. 4.

³Illinois State Civil Service Law, sec. 10.

when examination was impracticable. The Commission¹ ruled that the classification of "laborers" should include attendants and domestics of the state institutions. Application for these positions was to be made through the Department or the institutions and an eligible file maintained. Selection of employees from the eligible file was to be made by the Department, and the selected candidates referred to the respective institutions where vacancies existed. At each institution, the Managing Officer and Assistant Superintendent were to constitute a local Examining Board for the selection of attendants. The Board's selection was then subject to review by the Commission before appointment.²

Under this plan, discretion was allowed both in the Department and by the managing officer of the institution. And under the different administrations, each of these points has been penetrated by political control. The open politicalization of institution staffs by the Small regime is a matter of record. Under the Horner administration, political approval was centralized at Springfield. For appointment, the application of the candidate had to carry the approval of the patronage committee; this approval was to be obtained from the sponsorship of the applicant by the local political leader. The conditions of sponsorship, in terms of party affiliation, duties or contributions, were no concern of either the Department nor the Commission. From the Department's point of view, the injection of this intermediate step of political approval in the selection process was a necessary concession to the party machine, in return for appropriations and administrative freedom in other directions. It was a necessary step of "playing ball" with the party in power.³

With this policy in effect in the Department, the individual managing officer had to adapt his own institution to its

¹Rules of 1934, Rule XII, sec. 1.

²This practice was modified in 1939. On petition from the Board of Welfare Commissioners, the Chairman of the Civil Service Commission changed the above ruling, and established a competitive examination for the position of attendant. See Department of Public Welfare, Annual Report, 1939, p. 75, Report of the Board of Public Welfare Commissioner.

³Interview with Mr. A. L. Bowen, Director, Springfield, August 5, 1938.

limitations as best he could. If he was an "administration man" the policy was doubtless politically reasonable, however it may have affected the quality of his personnel. If he was primarily an administrator, interested in increasing the efficiency of his hospital, the effects were more irksome. His own powers of discretion were limited. Unless the employee showed physical defect or gross personal defect he had to accept him. The first three months of his employment were a probationary period; during this time the managing officer could release him without showing cause, and the employee had no appeal from this decision to the Commission. After the three months' probationary period was complete the provision for removal earlier described was applicable.

These powers, however, had marked limitations in practice. The managing officer was himself a political appointee. Again, if he was an "administration man" he would "go along" with the party's decisions and methods. If he was not an "administration man," his own position was insecure, and if he valued it, he could not afford to protest. In either case, if the appointee refused or dismissed had political connections, political pressure could be exerted on the managing officer in many devious ways--by visits or calls from local or state political officials, by the threat of dismissal of key staff, or of personal or professional recriminations. Against such pressures only an occasional managing officer would choose to struggle; it was easier to "go along."

These same pressures could be applied at other points for the removal of employees who were politically unacceptable however good their services. Not infrequently managing officers had to "find" places for numbers of new appointees whom they did not need nor want; such places could be had only by the removal of existing employees, for whatever trumped-up cause, or for no cause at all. The effect of such political turnover, both on the routine work of the institution and on the morale of all the staff, needs no further emphasis at this point.

Working Conditions

Once appointed, the hospital employee was faced by the prospect of a drab, routine employment, with little color, recognition or reward to offset the routine features. Institutional life at best is almost inevitably routinized; in the large mental

hospital, with mediocre and changing administration, the routine may become unbearable.

For this reason, large credit must be given to the preceding Board of Administration for the introduction of the eight hour day for attendants in 1914. The reduction from the longer twelve hour day had much to recommend it, yet in the face of increased cost the overcoming of legislative and administrative inertia to bring about the change was a definite achievement at that time. Its continuation since 1914 is to the credit of the various administrations, as pressures for so-called "economies" have been frequent.

The salary scale for the various grades of service is set out below. The salary scale, for both medical officers and nursing staff, is low; throughout, the salaries are only 60-75 per cent of those paid for identical posts in the states of New York and Massachusetts.¹ As with all states, maintenance is also provided for employees of all grades. However, if staff in Illinois choose to live outside the hospital, the commutation allowance for such living is markedly low--Illinois allows only \$24 per month, single or married person alike, for all grades of service. This allowance is below the cost of living for even a single person. New York State makes an allowance of \$80 per month for medical staff, plus \$40 additional for head of a family, or a total allowance of \$120 for a married officer; for non-medical staff allowances of \$50 and \$75 are made respectively. The extremely low allowances in Illinois are evident by comparison. It would appear that salaries and living allowances need appreciable increase in Illinois if a good grade of medical officer and staff

¹The Illinois salary scale is contrasted with those of Massachusetts and New York in the table below. The Illinois figures are those prevailing after the salary increases to medical officers made in 1939, and therefore are higher than those shown in Table 4.

<u>Position</u>	<u>Illinois</u>	<u>Massachusetts</u>	<u>New York</u>
Asst. Managing Officer	\$2,400-\$3,000	\$3,300-\$4,020	\$3,200-\$4,000
Senior Physician.....	2,280- 2,520	2,520- 3,060	2,400- 3,200
Junior Physician.....	1,800- 2,160	1,800- 2,400	2,000- 2,400
Registered Nurse.....	960- 1,140	1,320- 1,560	1,272
Attendant.....	600- 720	540- 840	648- 792

TABLE 4
SALARY SCALE
ILLINOIS MENTAL HOSPITALS
(As of August, 1938)

	Monthly Salary Scale			Maintenance ^b Allowance
	Minimum	Maximum	Automatic ^a Increase	
<u>Medical Staff</u>				
Managing officer ^c				
Assistant managing officer...	218.33	242.33 ^d	5.00	Self and family
Senior physician	192.33	218.33 ^e	5.00	Self and family
Junior physician	170.00	185.00	5.00	Self and family
Interne.....	150.00	160.00	5.00	Self and family
	.....	25.00	None	Self
<u>Nurses and Attendants</u>				
Chief nurse.....	110.00	140.00	5.00	Self
Registered nurse	80.00	95.00	3.00	Self
Supervising nurse.....	75.00	85.00	2.00	Self
Supervising attendant.....	65.00	75.00	2.00	Self
Attendant.....	50.00	60.00	2.00	Self

^aThe employee's salary is advanced this amount for each year of service.

^bMaintenance allowance includes shelter, three meals daily, and laundry.

^cManaging officers are not under Civil Service.

^dIn institutions of over 2,500 population.

^eIn institutions of less than 2,500 population.

is to be attracted to the service.

Wages and hours, however, are but one phase of institutional employment--an important one, surely, but a less important part of the whole employment picture in institutional work than in the community, where the employee can live at home and participate in non-institutional interests. In the institution the daily lives of most of the attendant and medical staff are a part of the institutional scheme. Their rooms or apartments are in

the hospital, often adjoining wards or in nearby buildings. They eat their meals in the hospital dining room. Their time off may be spent in the institutional recreation room or about the grounds. They live in the shadow of the institution to a degree only second to that of the patients.

This abnormal kind of life is further strained by its almost enforced celibacy among lesser staff. The salaries of medical staff permit marriage, and some sort of housing facilities are usually available for the married physician. But with the attendants and nurses less opportunity exists. The salaries do not allow marriage, and the hospital arrangements, favoring dormitory life with maintenance provided, are unfavorable to married employees. Hence many attendants are single, receiving a salary which will not permit marriage, and thus are bound to look on their hospital employment as a temporary one. This prospect again contributes to an attitude of indifference and lowered morale.

Still other factors complicate the outlook. For the attendant staff very little opportunity exists for promotion or advancement. Supervisory positions are few, and to be attained only by long service; their salaries are only slightly higher than that of attendant. Little machinery exists for adjustment of complaints, and there is little recognition awarded for outstanding performance. The constant turnover of employees is a standing suggestion to do likewise if dissatisfied.

Nor is there any provision for his disablement should this occur. The occupation of hospital attendant is generally recognized as being a hazardous occupation, and insurance rates for men are higher because of it. If the attendant is injured in the course of his duties, he is eligible for free medical care from the institution. But if the injury results in disablement and he is no longer employable, he receives no compensation for it. The Illinois Workmen's Compensation Act applies only to hazardous occupations; the occupation of attendant is not included.¹ Compensation is only possible by a suit against the state, through the Court of Claims. This is a difficult, expensive, and extended procedure for an employee on small salary, and offers him no real remedy. In fact, then, he also has to bear the element of addi-

¹Revised Statutes, 1937, c. 48, sec. 149.

tional risk on the job.

Finally, were he employed long enough to think of retirement, no provision is available to him within the state service. With the other disadvantages of the position, it might be reasonable to expect that the state would make special effort to provide a retirement provision, but none is available. Hence the employee has no security for his later years.

These sections describe an employment situation with a definitely negative outlook. Even yet, it would not be complete without mention of the existence of some other conditions, often of an irritating nature. These are of two sorts, the existence of "special privileges," and the prevalence of political assessments.

A large institution is a community within itself, and contains many supplies and services which are advantageous to employees. Depending on institutional policy these may or may not be available to the employee. Examples are legion, some of the most common being the obtaining of institutional supplies for personal use--vegetables, milk, groceries, fuel, gasoline, medicines, et cetera; the use of institutional services by employees--tailor, shoe repair, garage, beauty-parlor, dentists and physicians, to mention but a few of the many available services; the use of the institution's purchasing power to obtain discounts at community stores, or avoid payment of taxes, such as on automobile tires and equipment, radios, house furnishings or other large items of domestic use.

The number and variety of these services are so large that they are difficult to control. Some startling examples of abuses were noted during the Small regime.¹ They constitute a constant source of difficulty about the institution, and unless rigidly regulated, provide many a source of minor irritation, by reason of the inequality of application to different persons or groups, as well as opportunity for grafting--petty or not-so-petty. The resulting discontent among the staff is an additional thorn in the side of morale.

The question of political assessments is perhaps more familiar. Assessments for political purposes are expressly

¹See above, p. 46.

forbidden by the Civil Service Law,¹ yet it is common knowledge that they are constantly collected and no action is taken. A flat rate of 2 per cent of salaries a month is not unusual; on an already low salary the amount is appreciable. Even where flat assessments are not collected, there are frequent demands for contributions for political party funds, either of a direct sort or veiled in the guises of compulsory purchase of tickets for picnics, raffles or other political events. In view of the appointment and discharge methods earlier described, few employees can afford to disregard these "requests" and retain their positions.

For institutional personnel, then, working conditions are not conducive to security of tenure or satisfaction with the employment outlook. Insecurity faces the employee on every hand, and the state takes few steps to prevent or minimize it. Moreover, the existence of special privileges, and the constant demands for political contributions are irritating factors which contribute to dissatisfaction, lowered morale, and high turnover.

Personnel--Numbers and Adequacy

Personnel, adequate in number to allow proper care for the patients, is a prime requirement for decent standards of care and therapy. The number of personnel is also a working condition of importance, as insufficient staff means overloaded staff, and overloaded staff, irrespective of other working conditions, are incapable of using good practices in handling patients. And where other working conditions are poor, the insufficiency of staff becomes a large additional irritant. Unfortunately, such a condition has prevailed steadily under the Department.

The American Psychiatric Association, as the professional group most directly interested in the care of the mentally ill, has had for many years a Committee on Standards and Policies. It has been the duty of this Committee to examine the care given to the mentally ill in the hospitals of the country, and to set standards for such care. In 1925, the Committee presented, and the Association adopted, the Schedule of Standards for District,

¹Illinois State Civil Service Law, sec. 20.

State, and County Mental Hospitals.¹ These standards were not created arbitrarily but were based on careful inquiry into the then existing practices, in publicly operated hospitals; some of the standards were below the standards already attained by the leading states. Their utility as a yardstick is therefore based on sound experience.

The Standards have two sections applying to numbers of personnel, one to physicians, and the other to nurses and attendants. The requirement for physicians is:

There must be an adequate medical staff of well qualified physicians; the proportion to total patients to be not less than 1 to 150 in addition to the superintendent, and to the number of patients admitted annually not less than 1 to 40. There must be one or more full time dentists.²

The requirement for nurses and attendants is:

There must be adequate nursing force, in the proportion to total patients of not less than 1 to 8, and to the patients of intensive treatment and acute sick and surgical units of not less than 1 to 4. Provision must be made for adequate systematic instruction and training of the members of the nursing force.³

The application of these standards to the situation prevailing under the Department is set out in Table 5.

An examination of the table shows first that at no time in its life has the number of personnel employed reached the minimum standards of the American Psychiatric Association. The number of medical staff, while increasing, has never closely approached the suggested ratio of one physician to each 150 patients. The ratio has improved somewhat during the period recorded, from 1:130 in 1922 to 1:225 in 1937. In only two years, 1932 and 1933, did it fall below 1:200; these lowered ratios are accounted for by the larger numbers of internes then employed. It remains, however, 50 per cent higher than the standard requires; this is a heavy overload.

The ratio of physicians to admissions is set by the standard at 1:40. The Department experience again shows a slow improvement, from 1:102 in 1922 to 1:70 in 1937. The heavy over-

¹American Psychiatric Association, Report of the Committee on Standards and Policies, 1925.

²Ibid., sec. 4.

³Ibid., sec. 18.

load during the two "Small" administrations is sharply evidenced. The improvement since that time has been irregular; the recent condition continues to show heavy overloading.

The situation with nursing staff is similar. The standards call for a ratio of 1:8. The Illinois experience varies only slightly from 1:12 in 1922 to 1:11 in 1937, a hardly appreciable improvement in the period. Again, the overload continues impossibly heavy for nursing and attendant staff.

TABLE 5

STAFF-PATIENT RATIOS
ALL HOSPITALS, BY YEARS

Year	Numbers of Patients and Staff at End of Year					
	Medical Staff	Number of Patients	Ratio Physicians Patients	Number of Admissions	Ratio Physicians Admissions	Nursing Staff
1938-39.....	...	.....	...	.....	...	.....
1937-38.....	...	.....	...	.....	...	.....
1936-37.....	131	29,521	1:225	9,178	1: 70	2,582
1935-36.....	124	28,547	230	8,621	74	2,561
1934-35.....	111	27,233	246	8,232	62	2,452
1933-34.....	133	26,632	200	8,210	64	2,466
1932-33.....	123	25,870	210	7,796	57	2,265
1931-32.....	129	24,673	191	7,383	60	2,525
1930-31.....	123	23,859	195	7,347	71	2,241
1929-30.....	101	23,066	229	7,137	71	1,772
1928-29.....	74	22,039	298	6,758	92	2,227
1927-28.....	81	22,136	275	6,743	83	2,041
1926-27.....	75	21,384	285	6,152	82	2,158
1925-26.....	76	21,380	281	6,142	81	1,704
1924-25.....	76	20,905	276	6,070	80	1,765
1923-24.....	75	20,539	275	6,001	80	1,810
1922-23.....	66	20,070	304	6,215	94	1,844
1921-22.....	60	19,818	330	6,248	102	1,695
1920-21.....	...	18,927	...	6,210	...	.....
1919-20.....	...	18,016	...	5,807	...	.....
1918-19.....	...	17,886	...	5,894	...	.....
1917-18.....	...	18,264	...	6,626	...	.....

Year

CHAPTER V

ADMISSION, PAROLE, AND DISCHARGE

Admission of patients to the state hospitals is accomplished by one of two procedures, court commitment or voluntary admission. Both procedures require action by the local authority, the county, through the county court. Commitment is solely a matter for local jurisdiction; voluntary admission also requires the action of the county court. These procedures are fully described under the later section on the local authority.

The use of voluntary admission has been steadily increasing, but as yet accounts for only a part of all admissions (23 per cent in 1936-37). The bulk of admissions are by commitment. In these, the managing officer of the hospital has no discretion as to their reception; their admission is mandatory.

Upon the entry of an order of commitment of any insane person to a hospital for the insane, the clerk of the county court shall send a copy of the finding of the jury or commission and of the medical certificate provided for in section 9 of this act to the superintendent of the hospital for the insane to which such insane person is ordered to be committed, and such superintendent shall, without delay, admit such insane person as a patient in said hospital: Provided, that if there is no room in such hospital for the admission of the person committed thereto, and that such county shall have its full quota of patients in said hospital, the superintendent thereof shall return to said county one quiet, harmless chronic patient to any county which may be in excess of its quota; and should no county be in excess of its quota the superintendent shall select the most quiet, harmless chronic patient in said hospital and return him to the county from which he was committed, in order to make room for the patient recently adjudged insane: Provided further, if a hospital or asylum for the chronic or incurable insane shall be established, such chronic patient may be sent to such hospital or asylum for the chronic or incurable insane: Provided further, that in case it shall not be found possible to admit such patient to a state hospital or asylum for the insane, the court where such inquest is had may make such further order in the matter as may be requisite and lawful.¹

¹Revised Statutes, 1937, c. 85, sec. 17.

The commitment papers accompanying the patient call for standard face-sheet information, together with some data on his family history and illness. The latter information is in rigid questionnaire form of limited utility, and even so, is often only partially completed by the examining physician. From the relatives who may accompany the patient to the hospital additional information is sought, either at the time of admission or on later visits. On arrival at the hospital the patient is taken to a reception ward, where an initial examination notes his physical and mental condition at the time of admission.

Since commitment is mandatory to the hospitals, no committed patient can be refused. Although heavily overcrowded through many years, all committed patients were received, and there is no record that any hospital had to resort to waiting list procedure. Nor is there any evidence that managing officers resorted to the use of the exchange provision, as provided by the commitment law. Under this provision a managing officer, if his institution was crowded, could return one quiet harmless patient to the county in exchange for the new patient. Such procedure presented real difficulties unless the hospital had proper facilities for supervision of such patient in the local community. Lacking these facilities, particularly out-patient clinics and social workers, this provision for community care could not be utilized.

The provision for voluntary admission is a brief one:

Any person who may be in the early stages of insanity who may desire the benefit of treatment in a state or licensed private hospital for the insane as a voluntary patient, may be admitted to such hospital on his own written application, accompanied by a certificate from the county court of the county in which such applicant resides, stating that such person is a private or county patient as the case may be, and such person shall, if admitted to a state or licensed private hospital for the insane, have the same standing as other private or county patients; Provided, that all voluntary patients shall have the right to leave the hospital at any time on giving three days' notice to the superintendent.¹

The procedure is a simple one, and provides for due notice to the county court of the patient's intention to seek treatment.

The trend in voluntary admissions is shown in Table 6.

¹Ibid., c. 85, sec. 37.

TABLE 6

VOLUNTARY ADMISSIONS

Year	First Admission	Re-Admissions	Total	Total Admissions	Per Cent Voluntary	Voluntary Admissions on Close of Years	Per Cent of Total Number of Books
1936-37	1,428	691	2,119	9,178	23	1,654	5.6
1935-36	1,006	439	1,445	8,621	17	1,552	5.5
1934-35	1,207	473	1,680	8,232	20	1,356	5.0
1933-34	1,215	532	1,747	8,210	21	1,194	4.5
1932-33	1,092	395	1,487	7,796	19	1,195	4.6
1931-32	1,972	409	1,381	7,383	19	1,972	3.9
1930-31	697	284	1,981	7,347	13	728	3.1
1929-30	751	284	1,035	7,137	14	750	3.3
1928-29	600	219	819	6,758	12	671	3.0
1927-28	637	241	878	6,743	13	640	2.9
1926-27	529	175	704	6,152	11	540	2.5
1925-26	453	187	630	6,142	10	466	2.2
1924-25	458	193	651	6,070	11	534	2.6
1923-24	439	183	622	6,001	10	495	2.4
1922-23	384	199	583	6,215	9	503	2.5
1921-22	492	256	748	6,248	12	552	2.8
1920-21	355	160	515	6,210	8	408	2.2
1919-20	349	135	484	5,807	8	305	1.7

It shows a steady increase in the number of voluntary admissions, in both first admissions and re-admissions. As a part of all admissions, voluntary admissions show a steadily increasing proportion, increasing from 8 per cent in 1920 to 23 per cent in 1937. The fact that nearly one quarter of all admissions are now voluntary is of prime importance in the whole admission process.

The number of patients admitted voluntarily remaining at the end of the year also shows a steady increase. No figures are available as to length of stay of voluntary patients, but from the figures above it would appear that more voluntary patients are remaining for longer periods of time, as the number present at the end of the year increases throughout the period.

From the point of view of the hospital, the increased use of voluntary admission is an advance, but has some disadvantages. It is an advance in its recognition of the mental institution as a hospital, to which mentally ill persons come voluntarily for treatment. The widest possible public understanding of the mental hospital in this light is naturally to be desired. The disadvantage comes in the provision of the law which allows the patient to leave on giving three days' notice of his intention to do so.

Such a provision is probably necessary at present, to encourage the use of the voluntary admission process. Were it not provided, the prospective patient would not be disposed to enter the hospital, uncertain of his length of stay, or even of his eventual discharge. There is not yet enough general knowledge of mental hospital administration, or confidence in it, to give the patient such assurance; the shadow of the asylum still colors the public attitude, and understandably so in view of past and prevailing conditions.

The provision, however, is a disadvantage to the hospital in that it undermines any assurance on the physician's part that the patient will remain for a necessary course of treatment. The therapies for mental conditions are usually of weeks or months duration; they are often strenuous, monotonous, or unpleasant. The patient on admission may be ill enough to consent to them, or be persuaded to do so by his family or the physicians. As he begins to feel better, the need of treatment seems less necessary to him; he may be irritable or resentful or impatient with his

progress. Under such an attitude, he may decide to leave, give his notice, and depart. His departure may occur just at the point where the therapy has begun to be effective, and where a continuation of it would have insured fuller recovery; it may even occur at a point where a discontinuance of treatment may be dangerous to himself through the possibility of early relapse. Yet the hospital has no power to hold him, other than the persuasion of the physician. At times, family or friends may support the physician, but probably as often they also recognize some improvement in the patient, and wishing to have him at home for a variety of reasons, support his own desire to leave. Hence the hospital's therapy is not given a fair chance to restore the patient to full health.

This incomplete treatment has its effect in the community. The county court (and in smaller places, the community as well), knows when the patient leaves for the hospital. If he returns within a few days, there is a natural question as to the effectiveness of his treatment and his degree of recovery, in such a short time. A feeling of uneasiness may develop, and even dissatisfaction with, and mistrust of, the voluntary process, as offering insufficient protection to the community.

The hospital has few alternatives in the situation. In an extreme case, in which the patient may be positively dangerous to himself or others if released, commitment may be resorted to before he leaves the hospital, thus restraining him. But this is a highly undesirable procedure, as it violates the whole concept of the voluntary process, and creates distrust of the hospital on the part of the patient, his family and possibly his own community. It also militates against subsequent therapy, because of the probable nonco-operative attitude on the patient's part; he feels that he has been tricked and is resentful against the hospital authorities.

The situation is probably one which is inevitable as a result of our present state of transition in the treatment of mental disorder. The older criminal aspect is still strongly in the background, and expressed in the court proceedings; it is motivated by ignorance, fear, and desire for self-protection on the part of relatives and the community. The newer concept of mental disorder, with diagnosis, therapy, and possible recovery, has not

yet had sufficient demonstration and interpretation to the public. Until it has more widespread acceptance, so that patients and relatives alike will appreciate the need for consent to a proper period of treatment, this disadvantage will continue. Increasing interpretation to the community, however, should steadily lessen its influence. The means of such interpretation, through outpatient clinics, community supervision, and mental health education, are discussed at a later point.¹

Admission of Aged Persons

In his Annual Report for the year 1923, the Managing Officer of the Anna State Hospital made the following comment on the admissions of aged persons:

The population of the institution has steadily increased for the past few years. One of the most cogent reasons for this increase in number of admissions is the increase in admission of senile and arterio-sclerotic cases.²

The increase of aged persons in the hospital which he observed was not limited to Anna, nor to the year of his comment. In Table 7 below is given the age distribution for the first admissions of persons sixty years of age and over since 1922. It will be observed that the total number of first admissions increased from 4,792 to 6,583 during the period, an increase of 1,791 admissions or of 37 per cent. The increase in persons of sixty years of age and over during the period was from 916 to 1,768, an increase of 852 admissions or 93 per cent. The rate in increase of first admissions among the aged, therefore, is 2.5 times the rate for all first admissions; this is a marked disproportion. The increase is also a steady one, accounting for 19.11 per cent of all first admissions in 1922, and mounting to 26.8 per cent in 1937.

This trend is also confirmed in the diagnoses (see Tables 8 and 9). The two diagnoses applying to most aged patients are senility and arterio-sclerosis. In the ten year period, 1925-35, these two diagnoses accounted for 18.3 per cent of first admissions in 1925, 22.3 per cent in 1930, and 22.8 per cent in 1935.

¹See below, pp. 126 f.

²Department of Public Welfare, Annual Report, 1923, p. 136, Report of the Managing Officer of Anna State Hospital.

TABLE 7

AGE DISTRIBUTION OF FIRST ADMISSIONS
1922-1937

	1937	1936	1935	1934	1933	1932	1931	1930	1929	1928
Number of first admissions aged sixty years and over.....										
Total number of first admissions.....	1,768	1,912	1,660	1,708	1,520	1,342	1,289	1,235	1,178	1,081
Per cent of total admis- sions; those sixty and over.....	6,583	6,254	5,990	5,961	5,740	5,304	5,359	5,150	4,926	4,820
	26.8	29.0	27.88	28.66	26.48	25.31	24.05	23.96	23.92	22.43

(Continued)

	1927	1926	1925	1924	1923	1922
Number of first admissions aged sixty years and over.....						
Total number of first admissions.....	1,045	975	894	794	847	916
Per cent of total admis- sions; those sixty and over.....	4,409	4,387	4,428	4,284	4,770	4,792
	23.71	22.23	20.18	18.51	17.75	19.11

In the same period, patients with these two diagnoses increased from 1,468 in 1925, representing 6.9 per cent of the enrolled population, to 2,009 in 1930 (8.5 per cent), to 2,754 in 1935, or 10.0 per cent. In short, the number of aged persons in the hospitals increased steadily both absolutely and relatively to the whole population.

In general, this increase is to be expected with an aging population, both in the population of the country and the hospital population. But when the rate of increase of admission of aged population is 2.5 times that of the general admission rate, explanation must be sought elsewhere.

The Managing Officer of Anna State Hospital provides part of the explanation for the increase:

Many counties throughout southern Illinois have practically abandoned their almshouses. Most of the inmates of the almshouses of previous years have been adjudged insane and transferred to the state hospital. The remaining increment is so small that it hardly justified the pursuit of a constructive policy in regard to the maintenance of their respective almshouses. Many patients that formerly were cared for at county expenses are now committed to the state hospital.¹

The long drawn-out transfer of responsibility for the mentally ill, then, was still in progress in 1923, and probably later, with patients being transferred from the county almshouses and poor farm to the state hospital. These were years of farm depression; the rural counties were hard hit, and found this to be one way of throwing upon the state the former burden of county care.

Had the Managing Officer examined more deeply, he would also have found that an increasing number of aged persons were being committed direct from the care of their own families. This trend is shown for all Illinois, and, indeed, for the country as a whole. That it was more prominent in southern Illinois than for the state as a whole is shown in Tables 8 and 9. Table 8 shows that for the state as a whole the increase of commitments of patients with psychoses of the aged was small but steady, mounting from 18.3 per cent in 1925, to 22.8 per cent in 1935. Rates for individual hospitals, however, show marked differences. Alton and Anna, serving the south of the state, both show rates

¹Ibid., 1923, p. 137.

TABLE 8

PERCENTAGE DISTRIBUTION OF THE PSYCHOSES OF THE AGED
 SENILE AND CEREBRAL ARTERIOSCLEROSIS
 BY HOSPITALS; YEARS 1925, 1930, 1935

	1925	1930	1935
All psychoses.....	100.0	100.0	100.0
Total of senile and arterio- sclerosis only:			
All hospitals.....	18.3	22.3	22.8
Alton.....	24.6	31.2	28.5
Anna.....	23.5	38.6	31.0
Chicago State.....	26.8	28.1	37.1
East Moline.....	22.1	19.9	20.6
Elgin.....	11.9	13.5	16.3
Jacksonville.....	22.6	24.7	26.2
Kankakee.....	15.1	14.1	9.5
Peoria.....	18.1	19.4	25.1

in excess of the state average in 1925, sharp increases by 1930, and continued higher rates in 1935. For the year 1930, Anna shows the extremely high rate of 38.6 per cent, or nearly two aged patients in every five first admissions.

This striking trend in the southern hospitals is set out in detail in Table 9, which gives the percentage of aged commitments by years. It will be noted that for all hospitals, the rate increases slowly during the 13-year period. Alton, however, starts with a high rate, and shows sharp increases in the years 1929, 1933, and 1937. Anna, also starting with a high rate, shows sharp increases in 1927, 1929, and 1930. The southern part of the state experienced depression in both farming and mining during the 1920's, preceding the general depression of the next decade. Its families, less able to care for their aged relatives, sought relief through their commitment to state institutions.

Though the rates for southern Illinois reflect economic hardship, those shown for Chicago State Hospital are also noteworthy (Tables 8 and 9). Starting with the highest rate of any hospital in 1925, it retains a consistently high rate throughout the period. The sharp increase after 1931 is a product of two factors. The first is a change in commitment policy at the Cook

TABLE 9

PERCENTAGE DISTRIBUTION OF THE PSYCHOSES OF THE AGED
 SENILE AND CEREBRAL ARTERIOSCLEROSIS
 SELECTED HOSPITALS
 YEARS 1925 THROUGH 1937

	1925	1926	1927	1928	1929	1930	1931	1932	1933	1934	1935	1936	1937
All psychoses	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total of senile and arterio- sclerosis only:													
All hospitals.....	18.3	18.5	20.2	19.7	22.1	22.3	21.8	21.7	22.2	23.4	22.8	24.0	23.6
Alton.....	24.6	27.4	25.3	25.1	32.5	31.2	24.5	25.7	36.7	26.0	28.5	32.8	37.2
Anna.....	23.5	23.6	29.5	24.3	34.9	38.6	35.4	30.7	32.3	28.8	31.0	29.1	27.3
Chicago State...	26.8	22.4	23.3	25.6	27.8	28.1	29.1	35.4	33.4	35.6	37.1	38.0	38.1

County Psychopathic Hospital, whereby older patients were sent to Chicago State Hospital, and younger ones to Elgin, Kankakee, or Manteno. The second factor, however, is the economic one. The number of aged persons committed shows a steady increase with the depression years. Chicago families, no more than downstate families, could afford to care for their dependent aged.

Behind this trend lies the broader social and economic picture of families suffering from lower and lower incomes, slowly being shoved toward destitution and poverty. With more adequate incomes during the war years, they were able to care for their aged folk in their own homes. Faced with reduced income in the years since and with no form of public assistance or relief to aid them, economic pressure was a powerful lever in edging out the oldsters. Such an act on the part of a family is not a sudden decision, and may represent almost a crisis in family life--a crisis born of desperation. When there is food for all, family pride and affection strive to keep the aged at home. But when the family budget is strained; when the older folk take food from the children; when emotional tensions mount under the continued and growing strain, and older persons become increasingly dependent and unadaptable to the changing situation--then commitment seems to offer some relief to the harassed family.

The simplicity of the process lends support to the decision. Almost any old person has some idiosyncracies; these are often marked, and in most families are allowed for in the give-and-take of family life. But with sharpened tempers on the part of grandparents, parents, and children, personal differences become exaggerated, and a dramatic story can be made to the judge of the "danger" of the old person in the household--of his failing sight and hearing, his irritability, his scolding of the children, his mutterings and his threats. Lacking facilities for investigation of the home situation, the court accepts the statement and makes the commitment. And once committed, the aged person usually deteriorates rapidly, because of the emotional disturbance involved, the strangeness and bareness of the hospital setting, the total break with all he has been used to in the past. When the whole picture is obtained, it is often one of tragedy--a tragedy in which the villain, poverty, is all too often unrecognized.

With the advent of Old Age Assistance in the social security program of the state it could be expected that this trend might be checked. The assistance grant should permit the old person to be cared for at home, easing his economic burden to his family, or allowing for his care in some other home. To an extent this may happen, but there is little evidence of it in the early years of the operation of the program. There are other considerations in the picture and the largest of these is the inadequacy of family incomes.

It is a truism to say that the foundation of sound family life rests on sufficient income. Without sufficient income, the foundation is cut away at every point--by inadequate shelter, insufficient and improper food and clothing, lack of medical care, lack of proper recreation and social life. This impairment has serious effects on the members of the family--the parents, and particularly the children, physically and emotionally. Facing such an outlook for its immediate members, the present day family is hardly inclined to extend a welcoming hand and hearth to its old folk.

The extent of inadequate incomes among Illinois families is not exactly determinable but some impressive evidence is available to show that it is serious. In 1935, the Works Progress Administration made careful studies¹ of the cost of living in American cities. These costs were determined at two levels--the maintenance level and the emergency level.

The basic maintenance level represents normal or average minimum requirements for industrial, service, and other manual workers; the emergency level takes into account certain economies which may be made under depression conditions. The maintenance level provides not only for physical needs but also gives some consideration to psychological values. The emergency level allows more exclusively, though not entirely, for material wants, but it might be questioned on the grounds of health hazards if families had to live at this level for a considerable period of time.

The family whose costs of living are measured in this investigation is best described as the unskilled manual worker type. It consists of a moderately active man, a moderately active woman, a boy age 13, and a girl age 8. The man wears overalls at his work. No household assistance of any kind is

¹Works Progress Administration, Division of Social Research, Intercity Differences in Costs of Living, Research Monograph XII (Washington, 1937).

employed.

At the maintenance level, these four persons live in a four- or five-room house or apartment with water and sewer connections. Their dwelling is in at least a fair state of repair and contains an indoor bath and toilet for their exclusive use. They have gas, ice, electricity, and a small radio, but no automobile. They read a daily newspaper, go to the movies once a week, and enjoy other simple leisure-time activities. Their food is an adequate diet at minimum cost. They pay for their own medical care. Clothing, furniture, furnishings, and household equipment are provided with some regard for social as well as material needs. Carfare, taxes, and numerous incidental expenses are included in their budget.¹

The emergency level was a harsher one:

At the emergency level this four-person family has cheaper kinds of food to secure the same nutritive values as the maintenance budget provides. Housing is less desirable. There is less frequent replacement of clothing, furniture, furnishings, and household equipment. Household supplies are less plentiful; other services are reduced in quantity or eliminated entirely.

The authors properly emphasize the point that these levels of living are, at best, subsistence levels.

All the essentials of living are to be purchased at market prices; the budgets make no provision for home-grown food or home dressmaking. Complete self-support in all respects is provided for, but only on a current cost basis, since there is no allowance for carrying or liquidating debts or for necessary future expenditures, except small life insurance policies.

It is probable that neither of these levels of living has been defined before. The maintenance budget is not so liberal as that for a "health and decency" level which the skilled worker may hope to obtain, but it affords more than a "minimum of subsistence" living. The emergency budget, restricted as it is, represents a better level of living than most relief budgets allow.

Neither of these budgets approaches the content of what may be considered a satisfactory American standard of living, nor do their costs measure what families in this country would have to spend to secure "the abundant life." Such a standard would include an automobile, better housing and equipment, a more varied diet, and preventive medical care. Provision would be made for future education of the children and for economic security through saving. These and other desirable improvements above a maintenance level of living would necessitate annual expenditures considerably in excess of the money values of the budgets used in this investigation.²

For Chicago, the maintenance level was determined to be

¹Ibid., p. xii.

²Ibid., p. xiii.

\$1,356 per year, the emergency level \$973. For Peoria, Illinois (a city of 105,000 population located about 150 miles southwest of Chicago), the respective levels were \$1,274 and \$913 respectively. These figures are based on the needs of a family of four persons, two adults and two children.

In the same year, the U. S. Public Health Service conducted the National Health Survey¹ to secure basic information on the extent of illness and its treatment in the United States. Included in its information was the income of the families making up its sample.² For Illinois, data is obtainable for Chicago and for the small city of Normal, Illinois, located about midstate, some 40 miles east of Peoria.

At the same time, a national study of consumer incomes was in progress by the Natural Resources Committee.³ This study also used a careful sampling method. Its results are not available for individual states, but are presented for regions, Illinois falling in the North-Central Region.

From these two sources Table 10 has been compiled. For Chicago, it shows that 34.3 per cent of families in the city have incomes of less than \$1,000 per year; 57.4 per cent have incomes of less than \$1,500 per year. For Normal, Illinois, the corresponding figures are 40.4 per cent and 62.0 per cent respectively. For the North Central Region, the Natural Resources Committee finds percentages of 34.9 and 60.3 respectively. These distributions are in substantial agreement.

From interpolation between these figures, the following results are obtained. For Chicago, 51 per cent of the families in the sample had incomes less than \$1,274, the maintenance level of living. Below the emergency level of \$973 were 33 per cent of

¹U. S. Public Health Service, Division of Public Health Methods, "The National Health Survey, 1935-36" (Washington, 1938; mimeographed).

²The sample covered some 10 per cent of most urban populations studied. It was carefully selected and may be accepted as representative. For Chicago it comprised 13,221 families. For details of method used, see *ibid.*, "Significance, Scope and Method."

³Natural Resources Committee, Consumer Incomes in the United States (Washington, 1938).

TABLE 10

FAMILY INCOMES IN ILLINOIS
PERCENTAGE OF TOTAL NUMBER OF FAMILIES
IN CERTAIN LOW INCOME GROUPS
1935-1936

Percentage of Families Having Annual Incomes of Less Than:	Chicago (National Health Survey)	Normal (National Health Survey)	North-Central Region (Natural Resources Committee)
All families	100.0	100.0	100.0
\$1,000.....	34.3	40.4	34.9
1,500.....	57.4	62.0	60.3
2,000.....	76.4	79.8	76.5
3,000.....	89.5	93.6	91.0
3,000 and over..	10.5	6.4	9.0

the families. Accepting the adequacy and representativeness of the sample, these are striking figures. One-half of the city's families is trying to live on less than a maintenance level of existence, and one-third is forced below even an emergency level. Small wonder, then, that these families decide to commit their aged dependents to state care, or refuse to parole their recovered kin from state care. Such meagre incomes, necessitating rigid management for survival, offer no inducement to these families to care for additional dependents.

The downstate picture is similar. The figures for Peoria-Normal¹ show essentially the same findings. Below the maintenance level of \$1,274 were 54 per cent of the Normal families; 37 per cent were below the emergency level. While these percentages

¹The composite figure from these two cities needs explanation. The W.P.A. cost of living figures was available only for Peoria; the National Health survey figures of income were available only for Normal. Peoria is a city of 105,000; Normal is 6,700. This difference in size calls for caution in comparability of the figures. However, since they are only 40 miles apart, and since the North-West Region figures of the Natural Resources Committee Study supported the Normal series, they appeared useful. However, since the cost of living at Normal was not determined, the comparison is less accurate than the Chicago series.

might be modified somewhat due to their origin,¹ their interpretation is still clear--that large numbers of families in downstate Illinois towns and cities have incomes inadequate to permit standards of family life at even an emergency level.

The studies do not reflect conditions in wholly rural areas. But from the long years of depression of farm prices, and the straightened financial condition of many Illinois rural counties, the economic situation of rural families is certainly no easier than that of their city-dwelling cousins. And in the coal mining areas in the south of the state, desperate conditions have prevailed for years.² But since Illinois population is predominantly urban in distribution (74 per cent in 1930), the picture is essentially a fair one. With widespread economic distress prevalent, therefore, the struggle of many families to themselves survive would not indicate any early improvement in their ability or willingness to care for aged dependents in their hard-pressed homes.

It can be argued that in such cases, the pension grant received by the pensioner will be large enough to compensate his family for his maintenance, and that his cash income would make him an economic asset. Hence his family will be encouraged to care for him at home.

This claim has validity; the effect in encouraging family care will be measured by the coverage of old age assistance, and the amount of pension granted. For the year ending June 30, 1938, the Social Security Board reports 125,164 persons in receipt of Old Age Assistance in Illinois; these represented only 29.7 per cent of the population aged sixty-five and over (1930 Census). The bulk of the aged, therefore, are not in receipt of assistance. Many, indeed, are ineligible because of disqualifications of nationality, residence, and a theoretical ability of other relatives to support them.

The amount of assistance granted the 125,164 pensioners for the fiscal year 1937-38 was \$23,617,000; this is a consider-

¹See n. 1, p. 108.

²See Wilma Walker, "Distress in a Southern Illinois County," The Social Service Review, V (1931), 558.

able sum. The average grant per pensioner in June, 1938,¹ was \$17.90. While this grant approximates the national average of \$18.59 for the same month, yet it is insufficient to meet the cost of living of a single aged person. The grants are somewhat higher in the cities and lower in the rural areas. But inasmuch as Illinois population is predominantly urban, the inadequacy remains. And in many families with low income, even such a grant would not increase the family income to the W.P.A. emergency level.

Under these conditions, the presence of the pensioner in such a near-destitute household might well aggravate more problems than it would relieve. Such questions as what contribution the pensioner is to make to the family, the amount of his check he is to retain for his own use, and the care to be rendered in return for his contribution, all call for delicate handling. And they are unlikely to receive it in a family situation strained by long continued substandard existence. For these reasons the mere presence in the state of old age assistance of nominal amount is of itself a factor of limited effectiveness in promoting the care of the needy aged in their own homes.

The commitment of the aged to the state hospital, then, is a problem which has a considerable economic background. While the practice may be relieved to some extent by the spread of old age assistance grants, these are at present too few and too small to affect materially the total situation. The larger and more basic problem of inadequate family income is still to be met. Until it is more adequately met, economic pressure for commitment will continue and little reduction in the trend may be expected.

While the commitment of aged persons has undoubtedly been increased by shrinking family incomes, the question is raised whether or not commitments of patients at all age levels have not been increased by the same cause. A proper answer to this question would require a much broader study than the present one. In passing, however, some evidence from Illinois is in point.

In Table 11 there is presented a summary of the economic classification of first admissions for the years 1926 through 1937. It will be noted that there is a steady increase in first

¹Social Security Board, Third Annual Report, 1938, p. 205.

TABLE 11

ECONOMIC CONDITION OF FIRST ADMISSIONS
PERCENTAGES OF FIRST ADMISSIONS IN ECONOMIC GROUPS
BY YEARS, 1926-1937

	1926	1927	1928	1929	1930	1931	1932	1933	1934	1935	1936	1937
Number of first admissions.....	4,387	4,409	4,820	4,925	5,150	5,359	5,304	5,740	5,961	5,990	6,254	6,583
Per cent: all admissions.....	100	100	100	100	100	100	100	100	100	100	100	100
Total dependent and marginal groups:	88	90	92	93	95	95	93	93	93	89	87	90
Dependent.....	19	23	24	20	15	15	16	17	27	26	28	27
Marginal.....	69	67	68	73	80	80	77	76	66	63	59	63
Comfortable.....	10	8	7	6	4	4	4	4	4	3	3	3
Not ascertained.....	2	2	1	1	1	1	3	3	3	8	10	7

admissions during the period. There is a sharp increase in the size of the dependent group after 1933. The marginal group is always large, including from 66 to 75 per cent of all first admissions. During the period there is a steady decline in the size of the group in comfortable circumstances. More than 90 per cent of all first admissions fall into the dependent and marginal groups.

This evidence is suggestive only, but it may well direct serious attention to the relationships between the struggle involved in living at a marginal economic level, and related mental illness. Hastened mental breakdown may be one of the terrible prices the state (and the country) is paying for its callous disregard of reasonable minimums of human life.

Parole

Most patients show improvement or recovery during their period of hospitalization, and the time arrives for them to leave the institution. For this procedure two devices are used, parole and discharge. Parole is a conditional release; the patient is allowed to leave the hospital but remains under its supervision for a period of several months; his adjustment during this period gives evidence of his recovery or need of further treatment. If further treatment or supervision is indicated, he may then be returned to the hospital for another period without additional legal process. If continued supervision is indicated, his parole may be extended. The term "trial visit," as used in some states, is an appropriate description of its intent.

The hospital's authority to release patients on parole is set out by law:

Authority to discharge patients from either of the state institutions for the insane is vested in the trustees, but may be delegated, by a formal vote, to the superintendent, under such regulations as they may see fit to adopt. Discharges may be made for either of the following causes, namely: Because the person adjudged to be insane is not insane, or because he has recovered from the attack of insanity or because he has so far improved as to be capable of caring for himself, or because the friends of the patient request his discharge, and in the judgment of the superintendent no evil consequence is likely to follow such discharge, or because there is no prospect of further improvement under treatment, and the room occupied by an incurable and harmless patient is needed for the admission of others who are unsafe to be kept at large or

probably curable. Authority is also vested in the trustees to release the patients on parole for any term not exceeding three months; and, if not returned to the institution within that period, a new order of commitment from the county judge shall be necessary in order to [permit] the readmission of any such paroled patient to the institution: Provided, that the court may make such order upon the old verdict, if satisfied that the patient in question is still insane. But no patient who is violent, dangerous or more than usually troublesome or filthy, shall be discharged from any state institution and sent back to any county farm, almshouse or insane department thereof. And no patient who has not recovered his reason or who is charged with crime shall be declared discharged until at least ten days after notice shall have been given to the judge of the county court having jurisdiction in the case, in order to enable the said judge to make some proper order as to the disposition of the said patients, when so discharged, which order shall be entered of record, and a copy thereof furnished to the superintendent, and to the State Commissioners of Public Charities.¹

Under the Department the authority is exercised by the Managing Officer of each institution, as the Boards of Trustees were abolished with the creation of the former Board of Administration.²

The use of parole as a device for releasing the patient has increased steadily in Illinois, as shown by Table 12.

TABLE 12

PAROLES: BY YEARS
ALL HOSPITALS

Year	Total Number on Books During Year (Excluding Transfers)	Number Paroled	Per Cent Paroled
1936-37.....	38,341	4,322	11.30
1935-36.....	34,347	3,888	11.32
1934-35.....	34,864	3,486	9.99
1933-34.....	34,080	3,643	10.68
1932-33.....	32,469	3,427	10.55
1931-32.....	31,254	3,302	10.56
1930-31.....	.....	.....	.....
1929-30.....	29,178	2,339	8.01
1928-29.....	28,896	2,284	7.90
1927-28.....	28,127	2,556	9.08
1926-27.....	27,509	2,375	8.63
1925-26.....	27,053	2,675	9.88

¹Revised Statutes, c. 85, sec. 22.

²Ibid., c. 23, sec. 7.

The numerical increase has been steady. The relative use of parole also shows an increase, the percentage of the total number on the books during the year having risen from 11.30 in 1937.

The use of parole varies widely with different hospitals. Table 13 indicates this wide variation in the year 1935.

TABLE 13
PAROLES: BY HOSPITALS
YEAR ENDING JUNE 30, 1935

Hospital	Total Number on Books during the Year	Total Number Paroled during the year	Per Cent of Total Number on Books
Elgin.....	6,446	1,023	15.87
Kankakee.....	5,689	568	9.98
Jacksonville..	4,181	194	4.64
Anna.....	2,737	133	4.85
East Moline..	2,580	262	10.15
Peoria.....	3,440	225	6.54
Chicago.....	6,030	659	10.92
Alton.....	1,906	345	18.10
Manteno.....	1,937	76	3.92
All hospitals	34,946	3,485	9.97

There is no relationship between the size of the hospital and its use of parole. The highest incidence of parole, at Alton, is in the smallest hospital. The larger hospitals have higher rates, but the four largest have widely varying parole rates; Elgin, 15.87; Chicago, 10.92; Kankakee, 9.98; Jacksonville, 4.64. The explanation for the variation in use is to be found in the individual institution.

The use of parole by the individual hospital rests on a number of factors--the attitude of the managing officer toward it, and the reflection of his attitude on the staff, encouraging or discouraging its use; previous practices or policies about its use, which often continue automatically, granting paroles instead of discharges. Most important is the presence of an active social service department to follow patients in the hospital, make pre-

parole investigations, and provide follow-up service when the patient leaves the hospital.

The parole procedure also varies widely between different hospitals. In some, regular staff conferences are held for the purpose, to review the cases of those patients apparently ready for it, or for whom requests for parole have been made by the patient or by his relatives. The decision of the staff-conference may be final, or used as a guide to the managing officer. Other hospitals show a more casual procedure, the decision on parole resting with the patient's physician, or with an executive officer. The procedure in the same institution may also vary from time to time.

It is at this point that good staff organization is evident. Regular staff conferences to consider paroles (among other things) are an indication of good executive organization. Beyond this device, however, is needed a broader one of constant review of patients admitted and on the wards, with a view to their parole. In a large institution, with hundreds of patients per physician, it is easy for the patient to be forgotten. If he is insistent, or if his family is insistent, he will come to the physician's attention, and his parole be considered. But if he is an inconspicuous patient, who is withdrawn or retiring, or whose relatives are nonexistent or opposed to his return, he may well become the forgotten man, and slip into the groove of "chronic patient" without ever receiving proper consideration of his parole.

Particularly is this true of the patient whose skills are of value to the institution. If he is a good ward worker, or carpenter, or farmhand; if she is a good seamstress or dining-room aid, the utility of the patient may work against his proper consideration for parole. In the first place, he may be off the ward at the time of the physician's rounds and so fail to come to his attention. Or the attendant or service staff, realizing the patient's utility, may fail to call the physician's attention to him, knowing that it will mean heavier duties for themselves. There is urgent need, then, of a regular and frequent review of all patients for parole. This review should be a standing responsibility of the medical staff, or some officer of it. To this review a competent social service department can contribute

invaluable information and assistance.¹

Discharge

The device of discharge terminates the hospital's authority over the patient. He is not followed-up, and if in need of further or subsequent treatment, he must be recommitted by a new hearing, or re-admitted voluntarily. Discharge is usually used either in cases where the patient has recovered, or where he is unimproved and shows no response to treatment. It can be, and is, used in all kinds of cases, however, and no uniform practice prevails among the several hospitals.

The discharge process is again defined by law.² The procedure of notifying the County Court of the patient's discharge, as called for by Section 22, is loosely observed by the hospitals. In the case of a patient charged with a crime, care is taken to notify the Court before the patient is discharged, so that he may be turned over to the sheriff, if his case is to be prosecuted. But in other cases, the courts receive only occasional notice of a patient's discharge, and that usually after he has left the hospital. This provision is a carry-over from earlier years, when fewer patients were discharged from hospitals, and those, when they returned to their communities, were often marked persons. This provision was supposed to allow for continued surveillance of the patient by the local community as a potentially dangerous person. There is no record that it ever has had much use.

With the increasing responsibility of the state for the care of the mentally ill person, and the advances in therapy, the decision of the state's official to release the patient is accepted as satisfactory by the local authority. The latter has no means and no interest in following up the patient. This whole question of the subsequent adjustment of the patient, following the termination of the state's responsibility for him, is one of large importance. It is an area which is at present neglected, falling between state and local authorities and is the responsibility of neither. Because of its importance, it is made the subject of

¹See below, p. 134, for the review procedure as worked out at Kankakee State Hospital.

²Revised Statutes, c. 85, sec. 22.

later consideration.¹

It is the hospital's responsibility to see that the patient has sufficient funds to reach home: "No person shall be discharged from a state hospital or asylum for the insane without suitable clothing and a sum of money, not exceeding twenty dollars, sufficient to defray his expenses home, which shall be charged to the patient, if a private patient, and if a county patient, to the county, and collected as other debts due the institution are collected."² Here the state's responsibility, as defined by law, ends. Turning the patient over to his relatives, or putting him aboard the proper train or bus (usually after notice to his relatives, if they do not come for him), marks the end of the hospital's official duties.

On the patient's return to his own community, there are several processes which remain the responsibility of the local authority. These are the restoration of civil rights, where indicated, and the discharge of a conservator where one has been appointed, with the return of the patient's property to him.³ These continuing responsibilities of the local authority are significant. They direct attention to the much more important question--that of the subsequent welfare of the patient as a person. As previously indicated, this very important question is now nearly neglected, yet from the point of view of the patient's continued convalescence, his protection against relapse, and his continuing mental health, it is one of basic importance. It is therefore quite fully discussed in the final chapter.⁴

¹See below, p. 159.

²Revised Statutes, 1937, c. 85, sec. 23.

³Ibid., sec. 25.

⁴See below, p. 202.

CHAPTER VI

SOCIAL SERVICE

The development of social service work in the hospitals has been a gradual one but only in the past decade has it had firm organization. Sponsoring its early beginnings was a private agency, the Illinois Society for Mental Hygiene. This society, organized in 1910, was one of the several state societies which sprang up as part of the nation-wide mental hygiene movement. The movement at that time was much influenced by Clifford Beers, its founder, and because of his experiences, its efforts were directed at the improvement of mental hospital services.

One of its early services in Chicago was to provide a measure of social service to patients from the state hospitals. It provided a follow-up clinic in its own offices, using its own social worker. Chicago State Hospital later provided a physician for the clinic, one day per month; paroled patients were seen, and advice and assistance offered persons seeking help on cases of mental disorder.¹

An early effort of the Illinois Society was to have made a survey of the need for psychiatric services in Cook County. This effort was supported by the City Club of Chicago, and Dr. Herman Adler, then Professor of Psychiatry at the Harvard Medical School, was brought to the city in 1916 to make the study. Dr. Adler's report² outlined a comprehensive set of services for the county, including the expansion of case work services, and the provision of a center for research and teaching work in the new field. In the next year the Society was instrumental in bringing Dr. Adler to Chicago, as first appointee to the new post of State Criminologist; he also filled the post of Professor of Criminology

¹Illinois Society for Mental Hygiene, "Observations Made in the Psychopathic Hospitals in Chicago, August, 1929" (Unpublished manuscript, typewritten).

²Herman M. Adler, Cook County and the Mentally Handicapped (New York: The National Committee for Mental Hygiene, 1918).

and Medical Jurisprudence at the College of Medicine of the University of Illinois.

One result of this activity was the introduction of social work into the state hospitals. The first worker was Miss Marian E. Sheperd, who was appointed to Chicago State Hospital in 1918. Her appointment marks the beginning of social service work as an integral part of the hospital's services.

The unit for research and teaching recommended by Dr. Adler was organized in January, 1918. It was named "The State Juvenile Psychopathic Institute"¹ and was located at 1812 West Polk Street in Chicago, in the west side hospital group. Its program from the beginning included social service work, and provision was early made for the training of students. It aimed to supply case work service to the state institutions, and its final report notes cases referred from Elgin State Hospital, and from the State Training School for Girls at Geneva. It also notes that several social work students were assigned for field work training, some being from the School of Civics and Philanthropy of the University of Chicago.²

By virtue of its location in Cook County, the Social Service Department of the Institute could offer only local services; its plans were so directed. The concept of regional social service units throughout the state, however, was also formulated at this time, and had received departmental approval.³ The unit at the Institute fitted into this state-wide plan, functioning for the Cook County area.⁴ Social workers were also appointed at several other of the state hospitals.

The advent of the Small administration in 1921 brought stagnation to this promising development, though Dr. Adler continued as Criminologist, and Dr. Read became Alienist. The departmental administration, however, was of different calibre from

¹The name was changed in 1919 to "The Institute for Juvenile Research."

²"Report of the Juvenile Psychopathic Institute," Institution Quarterly, March, 1920, p. 56.

³See Harriet Gage, "A Plan for the Organization of a State System of Social Service," ibid., December, 1919, p. 5. This was a paper presented and discussed at a meeting of the Department in Springfield, September, 1919.

⁴Department of Public Welfare, Annual Report, 1920, p. 77, Report of the Criminologist.

that of Governor Lowden; under it, all welfare administration suffered severely.¹ Social work drifted along, lacking staff and leadership, and often weakened by the appointment of political personnel, who had little to contribute to the service.

Surprisingly enough, however, the turn for improvement also came late in the Small regime. Again under the impetus of Dr. Adler, provision was made for reviving social service work in the state hospitals. On July 1, 1928, a Chief of Social Service in Institutions was appointed, in the person of Mrs. Margaret Moffit Platner; Mrs. Platner had been Chief Psychiatric Social Worker of the Illinois Society for Mental Hygiene. In this position she was familiar with the work of the state institutions, and with their needs for social service work. From a departmental point of view, it is significant that although an Alienist was then in office he was at no time interested in the service; the Chief of Social Service was carried on the payroll of the Criminologist until the succeeding Administration, when, with a more sympathetic Alienist, her office was properly transferred to his division.

The immediate need of social service in the hospitals was for a structural framework. None had ever existed, and each worker did what he chose. With the increased number of hospitals and patients, problems of organization were a primary concern. The first move was to divide the state into eight districts, or zones, each centering in the state hospital in its area. The social service department in that hospital was then to be responsible for all work in that area, whether on the request of its own hospital or from another zone.²

This zoning plan was made particularly necessary because of the concentration of the hospitals in the northern part of the state. Three large hospitals served the Chicago area--Chicago State, Elgin, and Kankakee. The homes of the patients in these hospitals were chiefly in Cook County, and much confusion prevailed because of the necessity of the worker's travel from the institution into the city and return; the process was slow and

¹See chap. 11.

²Department of Public Welfare, Annual Report, 1929, p. 256, Report of the Chief of Social Service.

expensive. Under the zoning plan investigation of the home of a patient in Chicago would be made by the unit at the Chicago State Hospital, on request of the hospital housing the patient. A useful structural framework was thus established.

The objectives of the new division were set out as follows:

1. General supervision of the social service departments of the various hospitals.
2. Correlation of the work of the various hospitals, aiming at unified, intensive and constructive social service.
3. Emphasis on the parole process--the making of pre-parole investigations, and the follow up of patients on parole, to aid their readjustment in the community.
4. Correlation of the social service work in the hospitals with that of the various community agencies.
5. Direction of the study and training of social workers with regard to the causes of mental disorder, so that the Department may enter to some extent into preventative work, as well as the work of readjustment.
6. Education work in the field of mental hygiene in the community.

How well the new department was able to work toward these objectives during its decade of operation is examined in the following section.

The first decade of the department provides material for profitable analysis. Table 14 sets out in summary form the main activities of the department during the period 1928-37.¹

The number of cases handled shows a steady increase, from 6,547 in 1929-30 to 14,543 in 1937-38. During the period the number of patients under supervision increased from a monthly average of 676 in 1931-32 to 1,079 in 1937-38. In the same period out-patient clinic attendance rose from 2,661 to 4,097. This steadily increasing volume of work was handled by a staff which showed some, but not proportionate, increase in size. Its efficiency rose, however, as indicated by the mounting case load per worker.

¹These tables are prepared from the statistical data contained in the Annual Reports of the Chief of Social Service in Institutions.

TABLE 14
SOCIAL SERVICE IN INSTITUTIONS
SUMMARY OF WORK, 1928-1938

Year	Total Cases Handled	Average Number of Patients Supervised	Clinic Attend- ance	Social Workers	Cases Handled Per Worker
1937-38.....	14,543	1,079	4,097	19	765
1936-37.....	11,693	1,079	3,824	17	688
1935-36.....	10,362	969	3,476	17	609
1934-35.....	10,111	857	3,485	19	531
1933-34.....	11,207	829	3,695	18	621
1932-33.....	9,581	768	3,535	19	502
1931-32.....	8,747	676	2,661	22	396
1930-31.....	7,773	.....	.....	22	354
1929-30 ^a	6,547	.....	.....	16	410
1928-29 ^b	709	.....	.....	16	...

^aIncludes statistics from Peoria from December, 1929, through June, 1930. All other hospitals are for the full fiscal year.

^bThe state hospital social service zones were being organized during this year. Figures shown date from the opening of the zone through June 30, 1929.

Table 15 classifies the total number of cases handled by type--new, renewed, and carried over. It will be noticed that the new cases constitute the largest number of cases each year, and also show the largest increase during the period. This relationship would seem to indicate a healthy condition of growth, an increasing number of new cases being referred to the department each year because of demonstrated effectiveness in handling previous referrals.

TABLE 15
NUMBER OF CASES HANDLED, BY YEARS
ALL HOSPITALS

Year	Total	New	Renewed	Carried Over
1937-38.....	14,543	9,547	3,222	1,774
1936-37.....	11,693	7,666	2,439	1,588
1935-36.....	10,362	6,718	2,418	1,226
1934-35.....	10,111	6,090	2,388	1,633
1933-34.....	11,207	6,783	2,898	1,526
1932-33.....	9,581	5,831	2,619	1,131
1931-32.....	8,747	5,220	2,370	1,157
1930-31.....	7,773	4,757	2,010	1,006
1929-30.....	6,547	5,264	1,014	269
1928-29.....	709	709	.....	.....

Weight is added to this inference from Table 16, showing the source of referral of new cases. The hospital physicians refer the bulk of cases to social service; the volume of such referrals has doubled during the period, a sound and desirable growth. Referrals by social agencies show an increased but uneven

TABLE 16
SOURCE OF NEW CASES REFERRED, BY YEARS
ALL HOSPITALS

Year	Total	Physi- cians	Source		Relatives or Friends	Outside Zone
			Social Agencies	Own Initiative		
1937-38	9,547	7,656	94	57	11	1,729
1936-37	7,666	5,961	124	13	7	1,561
1935-36	6,718	5,265	141	25	12	1,275
1934-35	6,090	4,803	147	10	8	1,122
1933-34	6,783	5,182	150	19	40	1,392
1932-33	5,831	4,301	184	22	66	1,258
1931-32*	5,292	3,863	179	36	24	1,190
1930-31	4,757	3,584	47	26	24	1,076
1929-30	5,264	3,773	46	30	26	1,389
1928-29	.....	.....	...	..	..	.....

*Includes statistics from Peoria for 6 months only.

growth; other sources constitute a small part of the whole. Referrals from outside the zone are again chiefly those of physicians in out-of-zone hospitals.

The large and increasing use of referral by the hospital physicians is a sound development. It shows increasing recognition on their part of the function and value of social service assistance. This recognition, in turn, reflects good interpretation on the part of the social service department, both through demonstration on cases referred, and other educational processes. Such interpretation is greatly needed, and in view of mounting patient population, should be continued and expanded. Primarily, it is a matter of provision of more trained staff, whose daily activities constitute the soundest possible demonstration of their utility.

The activities of a mental hospital social service department are well indicated in Table 17, showing the reason for referral of new cases. Its chief activities are: gathering social histories, making pre-parole investigations and other investigations; less frequent activities include personal services to patients and arrangements for care of their families.

TABLE 17
REASON FOR REFERRAL OF NEW CASES, BY YEARS
ALL HOSPITALS

Year	Total Cases Referred	Reason			Care of Families	Personal Service
		Psychiatric Social History	Pre-Parole Investigation	Special Investigation		
1937-38	9,547	4,176	3,735	1,514	1	121
1936-37	7,666	3,463	3,605	443	2	153
1935-36	6,718	2,850	3,225	454	4	185
1934-35	6,090	2,416	3,127	377	2	168
1933-34	6,783	2,288	3,710	520	9	256
1932-33	5,831	1,875	3,223	576	29	128
1931-32	5,292	1,791	2,803	610	10	78
1930-31	4,757	1,571	2,444	545	23	174
1929-30	5,264	1,377	2,306	1,243	155	183
1928-29	.....	.....	.....	691	...	...

Of significance is the fact that until the year 1937-38, pre-parole investigations have constituted the largest number of cases. In that year, however, they were exceeded by requests for social histories, which requests had increased rapidly in the preceding several years. Although no explanation is offered, it may be inferred that the increase in number and quality of medical staff during these years brought a corresponding demand for good histories. In turn, the ability of the trained social workers to secure such histories has made them of greater value to the medical staff. With this increasing professional viewpoint in both psychiatric and social service departments, an even larger volume of requests for histories and pre-parole investigations may be expected in the future.

Here is well illustrated the desirable and productive teamwork of physician and social worker. The hospital physician, with his heavy patient load, is compelled to be an institutional person; he cannot, as can the family physician, visit the patient's home or know his family life. Yet this knowledge is of prime importance in the diagnosis and treatment of the patient. The social worker, skilled in the understanding of personal maladjustments and the evaluation of family and community factors in that process, is the fit and logical person to supply the needed information for the physician. In this way diagnosis is aided and treatment made more effective.

Moreover, another sound purpose is served by the social history: the family situation becomes known, so that parole or discharge is facilitated. Lacking this information in the social history, the physician has two choices; of paroling the patient into an unknown or uncertain family setting, or of having a pre-parole investigation made to determine it. The increasing resort to the second alternative is again evidence of sound professional practice; of knowing rather than guessing or hoping. In the lack of such basic information on the family and community setting of the patient, parole or discharge is at best an uncertain process; at worst it may be a grave tragedy.

The rendering of personal service to the patients, while small numerically, is often of large value to the patients. He may be admitted suddenly, without time to arrange his affairs in his family or community; the social worker, going to his home or

town can often arrange small matters to ease his mind. Or within the hospital, patients are in need of special services which the physician or attendant cannot perform. The social workers, knowing the community that is the hospital, with its varied services, can often assist or relieve the patient by drawing on these resources for his benefit.

Outside the hospitals, the largest responsibility of the social service department has been in staffing the parole clinics. These clinics, originated by the Illinois Society for Mental Hygiene previous to 1917, were continued by Chicago State Hospital under the Department, and adopted by some of the other hospitals. On the advent of the Social Service Department in 1928, it found nine clinics operating. The growth in number of clinics and their attendance since that time is shown in Table 18.

TABLE 18
STATE HOSPITAL PAROLE CLINICS

Year	Number of Parole Clinics Operating	Clinic Attendance
1937-38.....	20	4,097
1936-37.....	19	3,824
1935-36.....	19	3,476
1934-35.....	19	3,485
1933-34.....	18	3,695
1932-33.....	17	3,535
1931-32.....	19	2,661
1930-31.....	9	.....
1929-30.....	9	.....
1928-29.....	9	.....

It would be unfair to attribute the growth of the parole clinics wholly to the social service department. Naturally, the respective hospitals, with their managing officers and their medical staffs, have co-operated in their organization. Yet the initiative has often come from the social service department, because of its closer contact with the local communities, its awareness of the paroled patient's desire and need to see his physician, and its realization that the presence of the clinic permitted a larger number of patients to be paroled in that community, since

the clinic served as a large aid in supervision.

The parole clinic is an arm of the hospital, reaching into the local community. The Illinois clinics consist of the staff team of physician and social worker. The physician sees the patient; the social worker has made herself familiar with the patient's family and community situation, his adjustment to these on parole, his difficulties and his needs. The physician is given this information and utilizes it in the patient's treatment program while on parole. The social worker acts as clinic secretary, arranging for appointments and the carrying out of recommendations.

The values of the clinic are many. Held in the local community, at some place without the association of a mental institution, it eliminates any hospital stigma. Hence patients, parents, relatives, or guardians feel free to come, and can talk easily to the physician. Since the hospital comes to the community, factors of distance or costs of transportation are borne by the state, relieving the patient or his family of that expense. And having such local clinics available, the hospital physician is more ready to recommend parole, the managing officer to grant it, and the patient's relatives to accept it; it is a supervising device of largest importance. As a result, a larger number of patients can be paroled, with advantage to themselves and to the hospital, and considerable economic saving to the hospital, patient, and community. The whole question is a large one, with many important phases; these are more fully discussed later.¹ Clinics deserve much larger recognition and use than they have yet received in Illinois. The social service department is to be commended for its promotion of them.

The parole clinics are one factor in the steady increase of the number of patients under supervision on parole; Table 19 presents these figures.

The table also provides evidence in support of the zoning plan. There will be noticed a steady increase of patients paroled outside their zone of hospitalization. Such a supervised parole involves a pre-parole investigation, arrangements for the patient's return home, and subsequent supervision; it may mean care with relatives or friends. Were the zoning system not available,

¹See below, p. 202.

TABLE 19
AVERAGE NUMBER OF PATIENTS SUPERVISED
ALL HOSPITALS; BY YEARS

Year	Total	Patients Hospitalized and Paroled in Own Zone	Patients Paroled from outside Zone
1937-38....	1,079	561	518
1936-37....	1,079	657	422
1935-36....	969	633	336
1934-35....	857	569	288
1933-34....	829	511	318
1932-33....	768	474	294
1931-32....	676	428	248
1930-31*....	.....	...	...
1929-30*....	.....	...	...
1928-29....	485	...	...

*Figures not available.

providing universal social service throughout the state, with workers allocated in proportion to population, many of these paroles could not be made, or if made, would not be supervised. The zoning system facilitates the parole and provides the supervision, wherever the patient may happen to be within the state.

An important activity of the social service department which does not appear in the statistical report is that of research. The department has promoted several pieces of research during its life, and each deserves mention.

The first, largest, and most important is the parole study at Chicago State Hospital during the years 1930, 1931, and 1932. This was a study of possible parolable patients at that institution, to determine their suitability for parole, and the factors which were influencing the parole process. The initiative for the study came from Dean Edith Abbott and her associates of the Graduate School of Social Service Administration of the University of Chicago; the School also supplied technical supervision and considerable student assistance. The Alienist gave his support to the study, which was made under the auspices of the State Psychopathic Institute. General direction was provided by the

Chief of Social Service in Institutions, while Mrs. Florence Worthington, Chief Social Worker at the Chicago State Hospital gave it her immediate direction. The study has been fully reported elsewhere;¹ its findings and conclusions are of direct interest, however, and deserve attention at this point.

The study covered 348 patients who were referred by the physicians for social study. Of the patients referred, 212 were men and 136 women. The men were selected from wards of improved patients, the women from all the female wards (other than the receiving ward). Of the 348 patients, 58 were removed from the study for various reasons; 290 patients made up the group whose family situations were investigated. The results were as follows:

After this conference [for classification of the patient's suitability for parole] a social investigation was made to determine what were the possibilities for, or obstacles to, parole in each case. It was found that there were practical difficulties militating against parole in 269 out of the 290 cases. These difficulties were of the following types, more than one type of difficulty, of course, frequently appearing in a case: (1) the policy of not encouraging the parole of patients who were useful workers affected 132 men; (2) "economic factors," 71 men and 35 women; (3) "no relatives available who could assume supervision," 63 men and 35 women; (4) "relatives' homes not suitable for placement of patient," 89 men and 23 women; and (5) "patients unwilling to leave the hospital," 3 men and 7 women. Parole was arranged for 21 patients. Aside from the therapeutic value to 18 of these patients who were able to remain in the community, it was estimated that in 1930 their parole represented a saving to the state of from \$4,500 to \$5,400 a year.²

These factors preventing the parole of parolable patients are of three kinds:

1. Factors of institutional policy or practice, which operate to retain the patient in the institution.
2. Economic factors in the community.
3. Familial factors.

¹Florence P. Worthington, Suggested Community Resources for an Extensive Parole System for Mental Patients in Illinois (Smith College Studies in Social Work, June, 1933).

See also, Annie Laurie Baker, "Community Care for the Insane" (Unpublished Master's thesis, University of Chicago, 1931). This study was based on a part of the whole material.

²Worthington, op. cit., p. 336.

Largest and most direct is the factor of institutional practice. Of the 290 cases, 132 men, 71 per cent of all the male cases and 46 per cent of all the cases, improved or recovered and eligible for parole, were not paroled because they were too useful as routine workers, who could labor without supervision. When threatened with the loss of this "staff," the institution interposed to block their parole.

This finding points out a startling situation. Here are patients, mentally ill and committed to a public institution for treatment. On improvement or recovery, they are not discharged but retained in the institution indefinitely, to perform menial labor for the state. Here is an abuse of civil liberties which deserves much more thorough investigation. Thorough because the abuse is a widespread one, and committed under the guise of caring for helpless dependent persons. A sharp question is raised as to the line between mental institutions and prisons, and the state's abuse of its powers of guardianship over mentally ill and disadvantaged persons.

Economic factors in the community constituted a large barrier to parole. The effects of the economic depression were directly felt by the hospitals in two ways. If the prospective parolee had been employed before commitment, he probably lost his job thereby; or his job "folded up" during his period of hospitalization, and was not available on his recovery; or it had been filled by someone else, and no new job was available. And, of course, even if jobs were available, the ex-hospital patient was handicapped as an applicant if his hospitalization was known by the prospective employer. The lack of employment, therefore, placed the prospective parolee in the status of an economically dependent person, dependent on some other person for support.

The second effect was the additional strain placed on the parolee's family. In most cases family income had been reduced and possibly other members become unemployed. Youth with normal expectancy of securing positions and becoming self-supporting were unable to secure employment and remained idle at home. In such a situation the family cannot afford to accept another dependent member. Moreover, many families were crowded spatially. Depression had meant doubling up of families, or retention of youth in the home who would normally marry and move out; they may have

married but remained at home. The crowding of family living space became a marked problem in many homes. The return of the patient therefore presented a problem of living space. Additionally, of course, was the uncertainty about his mental condition, and his reaction in such a crowded household, with additional persons under foot, emotional tensions high and tempers on edge. In other families the mother may have gone to work in the absence of the patient, perhaps older children also, to piece together sufficient income for the family's support, and no adult remained at home to supervise the patient. Hence these disturbed family conditions, with overcrowding, dependency, and strain, militated directly against the parole of the patient. He was not wanted. Not infrequently the reply was given, "You keep him at the hospital-- at least he gets three meals and a bed there, and that's more than we've got here." Poverty was closing the door against the patient's return to his family.

The third factor, unsuitable family situations, was of course often complicated by unemployment. In other cases, however, it was less of a factor, and the home proved unsuitable for other reasons. In 51 cases there were no relatives, and in 36 cases broken homes existed. And where homes did exist they were unsuitable because of physical or moral conditions, the antagonism of relatives, or the lack of supervision. The average age of these patients was 50.1 years, not an easy age for readjustment in the home. Also the average length of institutional stay had been 8.8 years, a long period of absence from a family. In this long period family contacts had been broken, changes had occurred, and attitudes had changed. Many of these family factors combined to create home situations which made parole difficult or impossible.

These three factors frequently intertwined to prevent the actual parole of the patient. A familiar situation was the one in which the patient had recovered or improved, and was eligible for parole. Because of economic conditions neither he nor his family requested his parole, and he continued on indefinitely at the hospital, engaged in routine work, and steadily becoming older, more institutionalized, and more unfitted for readjustment in his family or in his community.

Questions of vital importance are raised by this study.

These questions relate to the purpose and administration of state mental hospitals and their unwarranted retention of recovered patients; to the need for broad measures for relieving the extreme distress in families caused by the depression, in order to permit more normal family life; to the lack of community services which would assist in the rehabilitation of paroled patients and other handicapped persons, so that they can again become useful, self-respecting persons in the community. Further consideration is given to these and related questions in the final chapter.

Following the study at Chicago State Hospital, a second study was made in 1933 at the East Moline State Hospital. Its purpose was to investigate the possibilities of extramural care for patients whom the hospital considered eligible for parole, but whose parole had not been arranged for by relatives or friends. East Moline State Hospital was selected because it served a rural area of the state, in contrast to the previous study in Cook County.

A marked lack of community resources for the paroled patient was found in the area:

The community resources for extramural care in that locality are meager. The resources have not kept pace with the development of facilities for intramural care. When the patient is ready for parole, the only resource of the hospital is to return him to relatives and, in many cases, to the situation which precipitated the mental breakdown. In cases in which relatives are unable or unwilling to provide adequate care the only alternative is continued hospitalization.¹

As one device for meeting this paucity of resources the possibilities of boarding home care for suitable patients was investigated and found feasible. Particularly indicated was the need for improved diagnostic facilities, so that unnecessary commitments could be avoided, and other plans made. The findings on this point are of interest:

The procedure necessitates careful examination of the patient before commitment. Under the present routine of admission in this hospital zone, the preliminary examination is comparatively superficial. Often it is made by physicians of the community, many of whom have had no special training in

¹Department of Public Welfare, Report, 1931-35, p. 51, Report of the Chief of Social Service in Institutions.

psychiatry. A local judge who was interviewed in the course of the survey expressed dissatisfaction with the present mode of commitment as he felt that examination of the patient by physicians unfamiliar with mental illness was of little help to the judge on whom fell the responsibility of deciding on a plan of care. The only history obtained is usually that taken from relatives who voluntarily present themselves for this purpose. When the patient happens to be the victim of a family quarrel or of unscrupulous relatives who do not have his interest at heart, the facts in the case may be misrepresented so that occasionally he is committed without adequate cause.

Granted more adequate diagnostic facilities, a more flexible program of care could be devised:

It seems reasonable to surmise, however, that as at the Psychopathic Hospital, certain patients could be sifted out and cared for adequately in the community without resorting to hospitalization, thus lightening the load carried by the institutions. This would involve an eventual saving to the State since it would curtail the building program necessary to care for the rapidly increasing population of the State hospitals.

Not only the economic factor but also the interest of the patient himself must be considered in a program of extramural care. It seems evident that resources such as those that have been found useful in other communities would be equally applicable in Illinois and would make possible a plan of care more economical and in many cases more suited to the patient than is possible under existing conditions.

This would necessitate adding only a few more trained psychiatric social workers to the staff to work closely with psychiatrists and adequate mental clinical facilities.¹

A third study was less formal, but was closely related to procedures of admission and discharge, and throws light on these processes. This study² was made at Kankakee State Hospital in 1933, by the social worker at that institution. At that time this hospital was overcrowded and desperately pressed for bed space. With the purpose of discharging every improved patient who was parolable, a card file was set up in which a card was placed on the patient's admission, to be reviewed three months later. This automatic review of cases brought to attention those who were recovered but not paroled, and directed effort toward their parole. The account of findings in this study is given below.

¹Ibid., p. 52.

²Ibid., p. 53.

In the six months dating from October 1, 1933 to April 1, 1934, two hundred and thirty-four patients were released, all having been admitted since July 1, 1933. The plan does not, and cannot, meet the increasing need for beds, but it has made a substantial contribution. This does not include by any means all the patients received there since that date who have been paroled. It represents those who had not gone and who had not been referred by the hospital staff. No doubt they would have been considered eventually and even shortly. However, as a result of this system they did go out more quickly than otherwise would have happened. The fact remains that at the time the tickler file brought them forcibly to the attention of the psychiatric social worker no one had said that they were in condition to leave. In this way the hospital was able, through a quicker overturn, to find more beds for new admittances.

The forerunner to this experiment was a study made a year earlier by the same psychiatric social worker at Kankakee of the 2,200 records of male patients. This careful effort resulted in the discovery of a good number of men who could have been released but who had been lost in their cottages for years because of lack of interest of relatives and lack of homes and friends. Many were patients whose commitment had followed alcoholic excesses and who could have returned to their families years earlier.

The chief obstacle in making plans for these men seemed to be the patients' own inertia, and contentment with life in the institution. They have been there so long; all ambition and initiative were gone. They did not want to leave, in fact they loudly protested. Also the relatives and friends, if any, had found it easy and pleasantly convenient to shift their responsibilities on the hospital. The patients had been misfits at home, sources of concern, embarrassment, or discord. Their relations had never been close and usually through the long years of hospitalization had broken entirely.

It was believed that if patients were kept in the hospital the shortest possible time consistent with their condition on arrival and progress to recovery, this deplorable condition could be partly prevented, especially in the cases of those suffering from alcoholic psychoses, as the home ties of such persons are apt to be at best but fragmentary. Also it was thought that before these patients had time to settle down in a niche of their own, and while they were still not lacking in initiative and the will to make good, they should be encouraged to leave and some pressure be brought to bear on their families to receive them.¹

These three studies point definitely to a large unmet need in mental hospital administration--that of a service for getting patients out. Patients are poured in by county courts and by voluntary admission from the region surrounding the hospital. Due to the large size of the institution and the rush of institutional activities, little attention is paid to the individual case. If

¹Ibid., p. 54.

the patient presses for his parole, or has friends or relatives to do so, he will probably be paroled. But for the thousands who need personal help or whose family ties are broken, insistent personalized service is necessary to accomplish their discharge. This is peculiarly an administrative task for the social service department. In Illinois, social service has had all too little opportunity to exercise it.

A description of the work of the department of social service would not be complete without reference to its personnel policies. For in this department the quality of its work depends wholly on the quality of its personnel. All of its expenditures are for services; the returns for the expenditures will depend on the quality of the personnel engaged in the work. Upon their qualifications--personality, training, and experience--must rest the success or failure of the department.

Prior to the organization of the department on July 1, 1928, there were 13 social workers in the 8 state hospitals. Chicago State had 6, Peoria 2, and each of the other hospitals one each except Kankakee, which had none. As shown by Table 20, only 2 of the 13 had professional training¹ for social work; 11 were untrained. The table shows an increase in the number of workers employed from 13 to 19 during the period. The number of untrained workers decreased from 11 to 5; these either acquired training or were replaced by properly qualified workers, who increased in number from 2 to 14 during the period. In the decade, then, substantial headway was made in laying the foundation for a professional staff. This achievement is the more significant in consideration of the facts that it was a decade of economic depression, and at times of drastic reduction in Departmental appropriations, and that three changes of administration occurred during the period.

The work of this personnel was somewhat augmented by the work of the students-in-training. It was the policy of the department to use its services for field-work training for professional social workers, and to this end a co-operative arrangement with the Graduate School of Social Service Administration of the

¹By professional training is meant one or more completed quarters of work in an accredited school of social work.

TABLE 20
SOCIAL WORK STAFF

Year	Number of Social Workers		
	Total	With Training	No Training
1937-38.....	19	14	5
1936-37.....	17	12	5
1935-36.....	17	12	5
1934-35.....	19	12	7
1933-34.....	18	14	4
1932-33.....	19	15	4
1931-32.....	22	13	9
1930-31.....	22	11	11
1929-30.....	16	6	10
1928-29.....	16	5	11
Previous to 1928.....	13	2	11

University of Chicago was in effect during the period. The number of students in training at one time varied from 1 to 5; they were located at Elgin or at Chicago State Hospital, and supervised by the Chief Social Workers of these hospitals. Additionally, other persons in training served internships of a month's duration at various times.

This training service was a mutually advantageous arrangement. To the School it provided field work experience for students in the field of mental disorder. To the department it likewise provided the assistance of the students. But more valuable to all was the opportunity to introduce students-in-training to the mental hospital field and to its related social problems. From the interest thus gained, a number of the students later joined the department's staff, doubly valuable workers because of their earlier acquaintance with its methods. Those who went elsewhere carried with them a wider knowledge of the problems of mental disorder, of benefit in the enrichment of their professional experience and in the broader field of education for mental hygiene. The training service, therefore, was a valuable one to the department and the student alike.

The size of the social work staff is small, and entirely inadequate for the volume of work to be done. Despite its small size, its increasing output of work is noteworthy, in the face

of the disturbed conditions of the decade. In considerable measure this increasing output reflects the increased competence of the staff through the addition of trained personnel. In part, also, it reflects the increasing co-operation of the social agencies in the community, and the momentum of experience and improved supervision. Such a constructive demonstration, in view of the overcrowded conditions at the hospitals and the causes underlying these conditions, is the strongest possible argument for an expansion of the service.

CHAPTER VII

EDUCATION, RESEARCH, AND PREVENTION

The slim activities of the Department in this area can be all too easily described. The work of the Psychopathic Institute, the Psychiatric Institute, and the Psychiatric Council, was earlier set out.¹ The research work of the Department is now centered in the Psychiatric Institute, maintained jointly by the Department and the Research and Educational Hospitals of the University of Illinois. The Department's total contribution to the Research and Educational Hospitals for the biennium 1937-39 was \$1,040,000; this appropriation also included funds for the Institute for Crippled Children. The expenditures for the Psychiatric Institute are not available, but even on the generous assumption that half the appropriation was spent for the Psychiatric Institute, this support of research activities would represent only 3 1/2 per cent of the total maintenance appropriation for mental hospitals in the same biennium.

Scattered pieces of individual research have been done in several of the hospitals, particularly at Elgin.² Some of these projects have been of good quality, but as a whole they have been disconnected, suffered from the lack of both financial and professional support, and from subsequent application of their results in practice. Some improvement in the latter respect may now be expected from the better circulation of information among the hospitals through the medium of "The Psychiatric Exchange." This publication is a mimeographed bulletin of practices in effect and research in progress at the various state hospitals and the Psychiatric Institute. It was established in January, 1938, for this purpose, appears bi-monthly, and circulates to the medical and professional staffs of the hospitals.

The efforts of the Department in the fields of public edu-

¹See above, p. 48.

²See the several volumes of The Elgin Papers.

cation for mental health, and for prevention, have been almost nonexistent. As earlier described,¹ the major instrument for these purposes, the community clinics, have been limited in number and more limited in scope, as they treated only paroled patients, and attempted no effort in community education for mental health. Though supplying the bulk of treatment for mental illness in the state, the Department has accepted no responsibility for educational work in mental health, nor for preventive services to forestall mental illness.²

Against this gray background of departmental apathy toward the necessity for early treatment and prevention, a recent development stands in bright relief. This is the organization and activity of The Association of Former Patients of the Psychiatric Institute. This unique Association was organized in November, 1937, primarily to combat the stigma of mental disorder which each member had experienced. Its formation grew out of the practice of group therapy at the Institute. Patients, recovered or improved, when paroled returned to the Institute periodically for lectures in a course of group therapy, designed to consolidate their recovery by giving them larger insight into their illness, its causes, and the mental mechanisms involved; this procedure was sound education for future mental health and for the prevention of future illness.

At these meetings the relation of individual experiences and difficulties of adjustment on parole brought sharply to attention the major difficulty faced, that of stigma in the community. However well the patient might be, his course of re-establishment in the community was invariably made more difficult by attitudes of suspicion and distrust toward him on the part of relatives, friends, and others. So general was the patients' encounter with this difficulty, and so keen was their resentment against it, that the Association was formed primarily to combat it by whatever means. Secondary motives included measures of

¹See above, p. 127.

²An exception might be made for the work of the Institute for Juvenile Research in Chicago, and its community clinics outside Chicago. These clinics are so few in number, however, that their work constitutes only a ripple in the large sea of need.

self-help through employment, exchange of services, and the like. As a means to both ends, as well as the promotion of group therapy and mental health, the Association publishes a bi-monthly magazine, Lost and Found, alive with vivid personal experiences and crusading spirit against its arch-foe, stigma.

Constructively, the first major effort of the Association is for a change in the present commitment laws, whose harshness and cruelty its members have so keenly felt. To this end it is devoting considerable research and promotional effort. It is to be noted that this development, urgently needed for years, comes not from the Department, which as guardian of the mentally ill might have been expected to initiate it, but from the former patients themselves, who have been driven to it by their own bitter experiences.

The similarity between the formation of the Association of Former Patients and that of the early mental hygiene societies is apparent. The dynamic for the latter groups came originally from the experience of Clifford Beers, his desire to secure reforms, supported by others interested in better care for the mentally ill. The Former Patients, though appreciating financial support from non-members, limit active membership to former patients. This limitation narrows the membership to a small, cohesive group, bound together by similar experience, and therefore one which should have a more concentrated drive toward their mutual objective--the removal of the stigma about mental disorder from the public mind.

No account of the mentally ill in Illinois during this period would be complete without mention of the Illinois Society for Mental Hygiene. This Society is a private organization, and has no connection with the Department other than a vital interest in raising the standards of care for mental patients.

The Society was incorporated in 1910, at a period when several state societies were formed following the publication of Mr. Beers' book, A Mind that Found Itself, and the subsequent formation (in 1909) of the National Committee for Mental Hygiene. The moving spirit in the formation of the Illinois Society was Miss Julia C. Lathrop, who was also a charter member of the National Committee. Miss Lathrop, as an active member of the State Board of Charities from 1893 to 1909, had visited all the

state institutions, and had paid particular attention to improving the care for the mentally deficient and the mentally ill. Jane Addams, in her biography of Miss Lathrop, refers to "her quiet but really dramatic description of the conditions she found in the institutions for the feeble-minded and the insane; how she described the men and women, sitting against the high walls of the long corridors, rocking and rocking, all with their hands folded and staring into space because they had nothing else to do day after day."¹

With her broad knowledge of conditions and her impelling desire for their improvement, Miss Lathrop eagerly welcomed the formation of the National Committee, and pushed forward the organization of the Illinois Society: here were agencies through which the miserable lot of the mentally ill might be improved, through education and enlightened public opinion. She served as the first president of the Illinois Society from 1910 to 1914, when she was succeeded by Mrs. William S. Monroe, the former secretary. Subsequent presidents were, Charles H. Thorne, first Director of the Department of Public Welfare, 1920-1922; Dr. H. Douglas Singer, 1923-1924; Dr. Ralph C. Hamill, 1927 to the present. From its inception, the Society has used a trained and salaried staff to carry on its program, though constantly making large use of interested persons, both lay and professional, in its community activities.

The Society's program has had wide scope, pressing forward on several fronts for improved services for the mentally ill and for broad measures of prevention. It has offered case work service to patients or to their families, or has referred them to appropriate agencies, physicians, clinics, or hospitals for service or treatment. It has promoted higher standards of care in existing agencies or clinics, or the creation of new agencies where needed, including school and hospital clinics for behavior difficulties for children and adults. The Society has urged improved training facilities for psychiatry in medical schools and schools of social work, and the necessity for related research work at these centers.

¹Jane Addams, My Friend, Julia Lathrop (New York: The Macmillan Co., 1935), p. 84.

Its educational program has aimed at disseminating accurate information about mental illness for public consumption. The means used include the publication of regular and special bulletins, newspaper releases, courses of lectures for laymen and for professional groups, and series of radio broadcasts.

Of particular interest to this study has been the Society's constant interest in, and work for, higher standards of care in the state hospitals. Through its Committee on Institutions, it has always maintained contact with the Governor and the Director of the Department of Public Welfare. These contacts have naturally been more effective with some administrations than with others. During the long doldrums of the "Small" administration the Society was one of the few groups actively concerned about the disorganization of the state hospitals, and made repeated efforts to check the downward spiral of lowering standards. These efforts produced few results at the time, but in view of the non-existence of the Board of Welfare Commissioners, the activity of the Society at that time, and in the following administration, was important as the chief organized effort for inspection and improvement.

The Society has directed its attention toward various institutional needs. The matter of plant was uppermost for many years, to the end that the acute overcrowding might be reduced, and decent, safe, buildings be provided to house the mentally ill of the state. Second only to housing has come the question of staff, adequate both in number and qualifications to provide proper care for these patients. On this point the Society has urged the practice of merit selection of all staff, including managing officers, the proper training and housing of this staff, and the payment of an adequate salary to them. The need for provision of out-patient clinics and for the expansion of social service facilities has constantly been stressed. In short, the Society's Committee on Institutions has been one of its most necessary and useful activities. Unfortunately, its work has been the more needed because of the lack of professional viewpoint and direction in the Department, and the weakness of the Board of Public Welfare Commissioners as the Department's advisory arm.

PART II

THE LOCAL AUTHORITY

CHAPTER VIII

THE FACILITIES IN THE COUNTIES: EARLY EXAMINATION, DIAGNOSIS, AND TREATMENT

The past hundred years has seen an increasing assumption of responsibility for the care of the insane by the state. In Illinois the state now provides for nearly all the custody and therapy for mentally ill persons, with the exception of Cook County, where the Psychopathic Hospital offers examination and short term therapy for local residents. The local authority, however, has retained certain of its original responsibilities, the chief of which is the commitment of the mentally ill person to the care of the state authority. Actually, there is a large area of responsibility which falls between local and state authorities and is covered by neither. In this area fall two important and neglected functions--the detection, examination, and early treatment of mental illness, and the follow-up of discharged patients in the local community. On this latter function the state has made a beginning but as yet reaches relatively few patients; the long time treatment of the paroled or discharged patient is still an unmet need.

The reason for these gaps is a simple one. The present law, and much of the present thinking, is still in the quasi-criminal terms of the nineteenth century--terms of protection against the insane person as a danger to himself and to the community; it is stated in terms of arrest, hearing, and segregation. The newer concept of mental illness, with its emphasis on early detection, diagnosis and treatment, and a supervised convalescence in the community, is one which has yet to be clearly recognized and stated in Illinois. Much educational and interpretative work has to be done to secure the public understanding and adoption of this point of view. And to this educational work the state has paid but little and belated attention.

In the local community, resources for the early care of the mentally ill person are both few and inadequate. A first

great difficulty for the patient and his family is the strong stigma which still surrounds mental disorder. In the majority of cases the early symptoms of the illness are behavior aberrations--the patient seems more withdrawn, more suspicious, or more irritable. As these manifestations are likely to be exaggerations of his previous behavior the family may pay little attention to them, or if they are noticed an attempt may be made to protect the patient and the family from comment by secluding him. In many cases even the family doctor will not be called because no physical symptoms or complaints are evidenced. Meanwhile the patient's condition becomes aggravated, his care increasingly burdensome to the family, and commitment is eventually resorted to. But the act of commitment may be weeks or months, often years, after the early symptoms have been noticed, and before the first formal examination is held and subsequent treatment applied. This time gap of months at best simply makes therapy more slow and difficult; at worst it may be the factor which separates recovery or improvement from chronic illness of a lifetime's duration. Hence its extreme importance, and the importance of its present neglect.

Stigma, then, is a pervasive deterrent to early treatment. The existing stigma attached to mental disorder is a product of ignorance, superstition, and fear--ignorance of the true nature of mental disorder; superstition, rooted in grandmothers' tales or local or racial lore which insidiously supplies its dark mixture of whispering and anxiety in the absence of knowledge and professional opinion; fear, rooted in the other two, and in the unexplained and unpredictable behavior of the patient, less often by his threats and his physical violence. In the community at large, such stigma is only to be dispelled by broad and continued educational measures. In the particular case, the family can be given relief from anxiety and positive help only by competent professional opinion, that of the informed physician or psychiatrist. And unfortunately in Illinois such help is not generally available.

Assuming that the family has a family physician, and has consulted him about the illness, they may or may not receive helpful advice. The present day practising physician has little more knowledge of mental disorder than has the average intelligent layman. Only within the last two decades have medical schools

included in the curriculum any training in psychiatry and with most schools at the present time it is given scanty attention. The understanding and treatment of psychogenic mental disease requires a broader viewpoint and appreciation of human behavior than the medical student is given time to acquire. In the absence of specific germs, symptoms, and treatments, so stressed in the rest of his medical training, he tends to dismiss mental disorder as "something screwy"--a field for the specialist, perhaps, but one for which he has no time or inclination.

The general practitioner, consequently, is not equipped to offer the family assistance in the way of understanding, therapy, or prognosis. His use is a great gain, moving the diagnostic process away from court and jailer into the medical field where it is properly placed. Yet beyond certifying the need of hospitalization the present day practitioner has little to offer the patient or his family.

Evidence of this ignorance of mental disease is to be found in the commitment papers received by the state hospitals. Though these papers are submitted by physicians, few of them are completely filled out, and even fewer contain any useful information about the patient's illness. Most of this lack is due to the ignorance of the physician himself on the subject of mental disorder. It is also to be attributed to the antiquated form of the interrogatory, and in part to the small fee (\$5.00) which the physician receives for acting on the commission. Frequently, in his opinion, the fee justifies only a summary history, if any.

If the more conscientious physician seeks a specialist in mental diseases to support his own judgment, he will find difficulty in securing one readily. In Cook County there are many, and the problem does not exist there. Outside of Cook County, however, there were, in 1938, only 11 physicians in private practice registered as specialists in nervous and mental diseases.¹ These 11 specialists served a population of some 3,600,000 persons in 101 counties. And of the 11, 7 were concentrated at two private mental hospitals, 3 at the Wilgus Sanitarium at Rockford and 4 at the Norbury Sanitarium at Jacksonville. All the rest of the state was served by only 4 psychiatrists, all located in the

¹American Medical Directory, 1938, p. 210.

northern half of the state. The general practitioner, therefore, has little specialized assistance in the private field on which to call.¹ His more available resources are the staffs of the state hospitals.

The medical staffs of the state hospitals are called on for a considerable volume of consulting work. This is never mentioned in their annual reports, but from the viewpoint of a community service is of large significance. The physicians in the hospital are known to the general practitioners of the district; there is constant and desirable professional exchange between them. As a result, a hospital physician is frequently called to "see a patient" for a physician in the district. Or the physician may bring his patient to the hospital to receive the benefit of the hospital equipment and diagnostic skill. At the present time, therefore, the hospitals act to a considerable degree as consulting centers on mental disorders for the physicians of their areas.

That the hospitals have not gone further in providing this consulting service to their communities is due to a number of factors. These are of a varied nature, such as the small size of the medical staffs available; their heavy institutional schedules; the isolation of the hospitals from the professional medical life of their communities; the uncertainty of the medical staff as to their community responsibilities, if any, outside of the hospital; and finally, the opposition of county medical societies to extra-mural work by the hospitals. These factors are worth broader consideration.

The first four factors named combine to discourage the hospital physician from community contacts. The traditional isolation of the old asylums had two roots. They were places apart, not only physically and in terms of community contacts, but in

¹Another facility which should be mentioned in passing is the private mental hospital. In Illinois, there are 9 of these institutions, all in the northern half of the state. Their total capacity is for some 550 patients. Their service is extremely limited because of their high charges, the usual minimum rate being \$20.00 per week. It is apparent that only a few persons of wealth can afford such private hospital care. These institutions are essentially hangovers from the nineteenth century, when it was a disgrace to enter a public asylum. They have nothing to offer the broad problem of care for the mentally ill in the state.

professional contacts as well. The hospital physician had a heavy patient load, which left him little time for, or interest in, community activities; his life was in the institution and he tended to remain there. Moreover, because of his uncertain professional and ethical status in the medical societies, as a salaried state employee in a strongly individualistic profession, he preferred not to sharpen the issue by increasing his professional contacts in the community.

The opposition of the medical societies is a different question. In the early outpatient clinics established in the state, there was a clear-cut expectation that these clinics would not only follow up paroled patients, but also offer consulting services to physicians and others in the local community; that they should provide a general consulting service in the field of mental illness. The following excerpt from an early report indicates the plan:

State Hospital Clinics

Experiments in extension work have been conducted by the state hospitals for the purpose of making available the consultation facilities of the hospitals in nearby communities; upon the theory that it is cheaper and more effective for the hospital to go to the people than to wait for the people to come to the hospital.¹

But in this activity the clinics soon met opposition from local medical men, expressed through the county medical societies. By seeing patients, the state was infringing on the field of the private practitioners; this was ground sacred to the feet of the private physician. If he wished, he might call in the hospital physician in consultation; that was his professional privilege. But should the hospital attempt to reach out into the community in furthering the cause of mental health, the whole foundations of medical practice were immediately endangered! Hence there was strong and continuous opposition to the parole clinics, even to their inception unless this was well explained, but always to their examination of new patients.² So effective was this oppo-

¹Department of Public Welfare, Report, 1920, p. 12, Report of the Director.

²A loophole was ostensibly left the state in that a clinic could examine a new patient "after securing the consent of the county medical society." In practice, however, the approach to the

sition that the out-patient clinics have never got beyond the point of parole clinics, limiting themselves to the follow-up of former patients.

That the original concept of the clinics was a much broader one is indicated above. But before these sound plans could be given expression the administration had changed, and the new administration was not interested in these extension services. By the time they were revived, ten years later, the resistance of the county medical societies had so crystallized that the state did not push the point of examination of new patients, then or since. Hence a valuable service of clinical examination, and of community education, has lain unused for the whole period.

This gap, then, remains large. Apart from the state hospitals, the facilities for the early detection, diagnosis, and treatment of mental illness are practically nonexistent. The local community offers nothing. The illness is denied, sheltered, or neglected until it becomes full blown and commitment is necessary. By this time the patient is so disturbed and the family so strained and upset, that the commitment process may become an explosive and destructive one to patient and family alike. The patient is then sent off, disturbed in mind, to a strange institution, to receive the understanding and care which was indicated months or years earlier. With such neglect, it is small wonder that the recovery rates in mental hospitals are low. Would the general hospital do better if every patient admitted was an emergency case, the resultant of years of misunderstanding and neglect? It is indeed a large demand on a hospital to ask it to apply effective therapy to such a patient. The recovery rate will continue to stay low until this neglect is remedied by the provision of public clinical services in every community.

medical society was difficult, and its consideration of the application so delayed that the device functioned as a damper on the clinic, as indeed it was intended to do.

CHAPTER IX

THE FACILITIES IN THE COUNTIES: THE COMMITMENT PROCESS

The commitment process, wholly a responsibility of the local authority, is set out in the statute.¹ A statement may be filed with the clerk of the county court by any reputable person, alleging the insanity or need of treatment of the mentally ill person. If this statement is not supported by a medical examination, the court may order one to be made.

A writ is then to issue to the guardian of the alleged insane person requiring him to present his ward at a court hearing on the affidavit. Meanwhile the county judge appoints a commission of two physicians to examine the patient and present its findings and recommendations to the judge in advance of the hearing. Provision is also made for jury trial, but such trials are now actually rare.²

The inquest may be in the court room or in the judge's chambers, or in the patient's home or other place at the discretion of the court. The presence of the patient is generally indispensable, though he may be excused by the presentation of an affidavit by some credible person (usually a physician) that he is unfit to appear. The inquest, however, may be informal in nature.

If commitment is recommended, and the court approves the recommendation, it will then enter an order of commitment of the patient to the state hospital. It will next direct the sheriff or relative of the patient to deliver the patient to the hospital. Two copies of this warrant are made; the first is receipted by the hospital and returned to the court as proof of delivery of the patient; the second is signed by the guardian of the patient on delivery and remains at the hospital.

Accounts of the actual working of the commitment process

¹Revised Statutes, 1937, c. 85, secs. 1-18.

²See below, p. 153.

throughout the state are available from two separate inquiries. The first of these was made by the State Alienist in 1937;¹ the second was a summary of the statutes of the various states with a special inquiry for Illinois.² The Alienist's inquiry related only to Illinois, that of Miss Breckinridge referred in part to Illinois. The content of the inquiries was similar and the findings are nearly identical. They have direct interest at this point.

The Department of Public Welfare, through the Alienist, has a general interest in the operation of the commitment laws. To ascertain their actual operation, the Alienist, in March, 1937, sent out to all county courts in Illinois a questionnaire covering certain phases of the commitment process.³ Information was requested on the place of detention of the patient awaiting hearing, the use of medical commissions and jury trials, the place of hearing, restoration of citizenship, the use of voluntary commitment, and suggestions for needed changes were solicited.

The inquiry was sent to all clerks of county courts in the state. Replies were received from Cook County and 73 of the counties other than Cook; 28 counties failed to reply. In 1930, 52 per cent of the state's population lived in Cook County; of the other counties the replies covered 78 per cent of their total population. The results, therefore, can be taken as representative of state-wide practice.

The first question asked for the place of detention of the patient awaiting hearing; to it 70 replies were received. Most courts reported detention at home unless the patient was violent, when confinement in jail was used (55 counties); 3 of these counties reported detention was "always at home." The remaining counties used the county almshouse or county home (6), local state hospitals (4), and the local general hospital (1).

¹The results of this inquiry are unpublished, but are summarized below.

²See S. P. Breckinridge, "Statutory Provision for the Commitment of Insane Persons," Social Service Review, XIII (1939), 221.

³The content and framing of the questions in this questionnaire left much to be desired, but despite its loose form it yielded considerable information.

Four courts interpreted the question as detention immediately preceding the hearing, and indicated that the sheriff's office or the courtroom was used for this purpose.

The great majority of hearings follow the examination and report by a commission of two physicians; 65 of the 70 replies so indicated. Most of these courts used commissions almost invariably. Jury trials were reported as extremely rare; in 100 commitments 18 courts reported no jury trials and 17 additional courts reported less than 5 in this number; 13 of these reported less than 2 jury trials in 100 commitments. It is apparent that resort to jury trials is becoming steadily more infrequent.

The hearings are usually held in the court building, either in the courtroom or in the judge's chambers; 3 courts reported no exceptions to this practice. The majority, however, indicated that the hearings were so held if the patient was able to appear; if he was bedfast or otherwise unfit to appear the hearing could be held in his home or other place of detention. That the court goes to the patient with increasing frequency is indicated by the fact that 6 courts reported hearings at the home of the patient in more than half of their commitments.

The use of voluntary commitment showed some interesting developments. The 71 counties answering this question reported a total of 2,472 court commitments for the year 1936, and 1,150 voluntary commitments for the same period; hence nearly one-third of all commitments were voluntary. In 10 of the counties voluntary commitments exceeded court commitments in the ratio of 640 to 389; the 640 voluntary commitments represented 56 per cent of the total of voluntary commitments in the 71 counties; the 389 court commitments represented 16 per cent of the total court commitments. These 10 counties varied in degree of use of voluntary commitment from approximately equal number of voluntary and court commitments to one in which the proportion was 114 voluntary to 46 court committed patients, a ratio of 2.5:1. This large use of voluntary commitment in certain areas is a striking development.

These areas proved to be those counties which contained state hospitals or which adjoined counties containing state hospitals. In other words, proximity to a mental health facility encouraged its voluntary use by the patient. At the same time it brought to the attention of the legal machinery of the area the

desirability and simplicity of the use of voluntary admission. This experience is informative testimony of the voluntary utilization of services for the care of the mentally ill by local communities when such services are made available. It presents a strong argument for their further extension and decentralization.

Two related points of the commitment process are covered by the second inquiry;¹ these are the question of payment of court costs and the matter of transportation of the patient to the hospital.

In answer to the question on the payment of court costs the replies indicated that the county usually paid these costs. Of 77 counties replying, the county paid the costs in 33 cases; the county or the patient's estate in 24 cases; the county or a relative in 17 cases; the sheriff in 1 case and the state in 1 case.² In only one county was the petitioner named as responsible for the court costs. It would appear that the local authority has itself accepted the responsibility for the expenses of the commitment process where the patient or his family are unable to meet them.

The question of transfer of the patient to the hospital has two phases, one of cost and another of therapy. As to the guardian of the patient in this transfer, the law is broad and allows relatives equally with court officers for the purpose:

18. For the conveyance of any patient to a hospital or asylum for the insane, the clerk shall issue a warrant, in duplicate, direct to the sheriff or any suitable person, preferring some relative of the insane person, when desired, commanding him to apprehend such insane person and deliver him to the superintendent.³

The actual practice shows that the use of the sheriff as an agent of transfer still predominates. The counties report that the sheriff alone transfers the patient in 33 counties; the sheriff or a member of the patient's family in 30 counties; the

¹Breckinridge, op. cit.

²No explanation is offered of this procedure of state payment. The payment of costs by the state to a county court is at least irregular, but is in line with the expanding assumption of local responsibilities by the state.

³Revised Statutes, 1937, c. 85, sec. 18.

sheriff or a relative in 13 counties; a relative alone in one county, and in one county the agent of transfer is designated by the judge.

The agent of transfer may be influenced by the patient's resources (or his family's). Transfer of patients by automobile is now universal. If the family has a car, or can arrange for the use of one, and relatives are able and willing to accompany the patient, such a method of transfer would appear desirable.¹ But many families cannot arrange for transportation, and the county has to provide it through the sheriff. A humane sheriff will request a relative to accompany the patient,² not only for reasons of reassurance of the patient and his family about his proper treatment, but also for his own protection, either against physical interference on the part of the patient or against subsequent allegations of mistreatment on the part of delusional patients.

The essential requirements of transfer are that it should be prompt, comfortable, and not aggravate the mental condition of the patient. The general use of the sheriff for this purpose raises questions on these points. In some few cases, he may be the logical agent of transfer, cases in which the patient is homicidal or where no relatives exist or are available. His fitness in other cases is open to question. The duties of the sheriff are primarily concerned with the enforcement of the criminal law--in the apprehension and detention of offenders. His office is frankly a political one, without requirements of personality, training, or experience. Consequently the person elected to the office may be one with limited education and little understanding of either the law or of human behavior. He shares the community's ignorance of mental disorder, and hence, relying on methods of fear and force with alleged or convicted offenders he tends to apply the same methods to the mentally ill person. Inasmuch as the patient is already acutely disturbed at this point, the con-

¹An exception might be made in those cases in which the patient is hostile to his family or relatives, and where their company would make him more disturbed. In such cases a neutral party might be less disturbing to the patient.

²The Illinois law requires a female patient to be accompanied by a female attendant.

tact with the sheriff and such forceful methods is terrifying and seriously disturbing to him; his fears and anxieties may be deepened and subsequent therapy made more difficult.

This question of the handling of the patient during his transfer, and his approach to the hospital, suggests two related points. The first is the great dearth of psychiatric facilities in the community, so that the relatives cannot secure competent advice for themselves on the needs and treatment of the patient, and also have the benefit of much needed help in the interpretation of his needs of treatment given to the patient himself by a competent specialist. The question is also raised whether the state should not extend its hospital services to include the transportation of patients to the hospital. There are strong indications for the need of such an extension. The state already has the responsibility for the patient's return to the community, occasionally accompanying the patient by an attendant where indicated. Again, experience in other states has indicated the wisdom of this policy and 15 states now make provision for the transfer of the patient to the hospital by a special attendant.¹ In 14 of these states the attendant is from the hospital, while in Colorado the judge must designate a trained attendant to accompany the patient.

The basis for such provision is essentially therapeutic. The acutely ill patient entering a general hospital is transported in an ambulance, accompanied by skilled attendants. No less a service is needed for the acutely ill mental patient; he is in need of the most understanding and skillful care which can be provided. While the present day attendant from the Illinois state hospitals is hardly a superior person in these respects, he is at least one with some rudimentary appreciation of mental disorder, and has received some instruction and experience in the proper handling of patients. Indeed, a strong case can be made for assigning to this important service specially skilled attendants and nurses, as a part of the admission process. The understanding attitude and the helpful skills of such attendants, even though strangers to the patient, could do much to reassure him and his relatives and ease his whole approach to what to him is

¹Breckinridge, op. cit., p. 238.

a strange and often fearful institution. The plain humanity of such a provision is its strongest argument; its proved therapeutic values make it doubly desirable.

Both inquiries invited suggestions for the improvement of the commitment process. On the whole there was a surprising lack of response to this invitation. Of the 71 replies to the Alienist's inquiry, 29 courts failed to answer the question and 23 additional indicated a laconic, "None"; more than two-thirds of those replying were satisfied with existing arrangements, or at least if not satisfied offered no suggestions for improvement. This attitude is also indicated in the comments which were made in the Alienist's inquiry and in several of the replies in the second study. From the viewpoint of most of the legal officials the present laws and machinery are satisfactory.

Among the comments received, however, the point most frequently stressed was the abuses of the commission procedure and the need for competent psychiatric opinion. Several judges expressed doubts as to the ability of the average general practitioner to identify mental disorder and to be discerning in recommending commitment. Too often a casual recommendation was made of the patient followed by a routine recommendation for commitment. In some instances the County Medical Society requested that the court distribute the work of certification among its members, reflecting a viewpoint that the examination and certification of an alleged mentally ill person are a routine process, independent of special competence or skills. To the medical society the commissions represent merely so many fees, a source of income to be pro-rated equitably among the group. The fact that one judge clearly recognizes the function of the court in protecting the patient against the recommendations of the commission indicates the routine process which certification tends to become. Unfortunately few other judges showed such awareness of the court's function in this respect.

That this protection of the alleged mentally ill person from the physician is needed, however, is clearly indicated from another source. This is the evidence of the patients themselves, after recovery and review of their experiences of commitment. This experience has now become articulated and has been recently expressed through The Association of Former Patients of the

Psychiatric Institute. Their viewpoint is of particular weight and importance, and is referred to in detail below.¹

The prime need recognized is for additional psychiatric services as an aid to the court. It is not surprising that a few judges should recognize this need, in view of the thousands of commitments passing through their hands each year, and the vagueness of the general practitioner about the patient's conditions and treatment. There should be available to every county court competent psychiatric opinion on any mental case before him, whether or not the question of commitment is involved. And that psychiatric opinion can be most easily and satisfactorily supplied by the Department itself, through its hospitals and clinics. The provision of such service through the extension of these facilities into community service is directly indicated.

¹See below, p. 162.

CHAPTER X

THE PATIENT'S RETURN TO HIS COMMUNITY

At the conclusion of his period of treatment in the state hospital the patient returns to his community. In most cases his family, relatives, or friends assist in his return, providing transportation and supervision; where this is not done the hospital has the responsibility for the patient's transportation and clothing. For a fraction of returned patients it may also supply occasional supervision in the community through the parole clinics or the social worker.

The local community, of which the patient was a citizen and in which he has made his home, makes no provision for his return. It has no responsibility for his condition or care; it receives no notice of his impending return, and for the most part it is indifferent to his return and subsequent welfare. This lack of continuing responsibility for the welfare of the patient is the second of the large gaps in the existing services in Illinois. Through the parole clinics the state has made a beginning toward exercising such responsibility. However, the clinics are so few in number and small in staff that they can reach only a fraction of the patients in need of such service.

The older concept of insanity accounts in part for the existence of this gap. In its view a person is either sane or insane. If sane, he should be able to conduct his own affairs in the community without help; if insane, he should be in an institution. If he has "recovered from an attack of insanity" he is fortunate indeed to be at home, and his discharge from the institution may be sufficient proof of his own restored abilities. In this case, however, the attitude is strongly tempered by the considerations of his "attack" and its associated stigma. Though he may have been discharged from the institution as recovered, is it not common knowledge that "once insane, always insane"; therefore his subsequent behavior is to be viewed with suspicion. It is this attitude of doubt and suspicion of the recovered

patient which forms the core of the stigma in the community today, and which makes the patient's subsequent adjustment vastly more difficult.

This older concept was always artificial. Mental disorder cannot be so neatly classified; it exists in every degree of severity, and institutional treatment is only part of the whole treatment process. The majority of persons with mental illnesses are not in institutions, but in the community; they may or may not have been so diagnosed, and may or may not have had the benefit of institutional care. Many persons with mild mental ailments make their own adjustment in the community, often continuing in self-supporting employment. A larger number may be unemployed or unemployable but continue to live at home or elsewhere, making a satisfactory adjustment in a protected environment; persons in these two groups may never be diagnosed or committed, nor is it necessary to do so.

Of those who are committed, most return to their own communities sooner or later. They may return as recovered, improved, or unimproved; the number who are discharged as not recovered is impressive. Table 21 gives these data for the year 1936-37.

TABLE 21
CONDITION OF PATIENTS ON DISCHARGE
ALL HOSPITALS
1936-37

Condition	Number	Per Cent
All discharges.....	5,315	100
Recovered.....	858	16
Improved.....	2,632	50
Unimproved.....	388	7
Without psychosis.....	1,437	27

In the year, 5,315 patients were discharged from the state hospitals. Of this number, only 858, or 16 per cent, were discharged as recovered. The largest group, 2,632 patients, or half the total number, were discharged as improved only. An additional smaller number were discharged as unimproved, and 1,437 patients,

or one-quarter the total number, were found to be without psychosis. In short, 84 per cent of all the patients discharged in this year were classified as other than recovered.

This situation is not unique; it is the typical experience of Illinois hospitals over several decades, and is found to apply universally. Its interpretation is that most of the patients returning from treatment in state hospitals are not recovered but only improved; being so they are obviously in need of continued care and supervision in their own communities. As earlier noted, the importance of this situation is not recognized and as a result the resources for supplying this continuing care are almost wholly lacking. One obvious result is that the re-admission rate in the hospitals stays high, and many patients are forced to return to the hospitals for the care that could be more easily and inexpensively provided in their own communities.

There are several cogent reasons why this aftercare is particularly needed for the mental patient. A chief one is the sharp contrast facing the patient on his discharge between his sheltered experience in the institution and the tougher reality of life in his family and in the community. Frequently his earlier inability to make these adjustments has contributed to his illness and commitment. In the institution he leads a highly sheltered life. As a bed patient he is wholly dependent; as an ambulatory patient there is little effort on his part to fit in to the well-defined routines of hospital life. All his necessities are provided at his elbow--shelter, food, clothing, employment, medical care, recreation. Little initiative or choice is necessary, as a constant variety of pressures are played on him to direct his behavior. In these daily functions he may evidence an automatic sort of performance, but this lack of spontaneity is usually viewed as an advantage by the lesser staff; to them he may be the ideal patient, tractable and unquestioning. In a very real way the institution may be unfitting him for later self-maintenance in the community.

This cloistered existence is sharply changed on his discharge. He again finds himself, perhaps abruptly, in the give-and-take of family and community life, facing constant decisions relating to his food, clothing, employment, recreation, and social life. Such a stream of inexorable situations, each involving

alternatives and conflict, but always decision--his own decision--is a rigorous experience after the simplified, automatic life of the institution. To meet it successfully he needs the help of sympathetic understanding and frequent assistance. These may be present in the family situation, but often the family itself needs awareness of his difficulties and help in meeting them. And in cases where the family rejects the patient, or no family exists, these needs must be met by other agencies; the community clinic is the logical agency for the purpose.

Fresh emphasis has been given to this need for aftercare by the wide use of the so-called "shock" treatments of insulin and metrozol with schizophrenic patients. These treatments have increased the recovery rates in this disorder; more patients are recovered or improved than formerly. There is therefore need of more follow-up care for this increased number of patients.

Additionally, however, there is an important qualitative need. One effect of these treatments, in more fully restoring the patient to his normal state, is to make him more alert and sensitive to conflicts and difficulties. From the experience at the Psychiatric Institute, Dr. Low makes the following observation:

The patients who made a full recovery after insulin and metrozol therapy are more alert and critical, more responsive and sensitive than were the patients who, in previous years, had spontaneous remissions. Being more sensitive, they are more easily hurt by the provocations and indignities of the stigma situation. In years past, when the returned patients met with the stigma they submitted to it in passive resignation; today they resent it with active indignation.¹

It is heartening that the reaction of the patients of the Institute, in their indignation, has turned to the constructive effort of education to remove the all-pervasive stigma; effort from every source will be needed in this battle. This educational effort, however, is a long-time process. These recovered patients are meanwhile in need of understanding, encouragement, and assistance; their families and communities need direct interpretation and help in furthering and stabilizing their recovery. Such

¹A. A. Low, in Lost and Found, Bulletin of the Association of Former Patients of the Psychiatric Institute, II, No. 1 (January, 1939), 7.

assistance again calls for widespread clinical services. It is to be noted that the educational function of these clinical services goes hand in hand with their therapeutic work; the two are inseparably interwoven. In this battle against the age-long stigma the clinic has a strategic part to play in the local community.

Consideration was given earlier to the services which the local clinic could render to the court in the commitment process. A second phase of this clinic-court relationship occurs in the rehabilitation of the patient in the community through the restoration of his civil rights and control over his property. On the present operation of these procedures the Alienist's inquiry is informing.

On adjudication of insanity, the patient's rights of citizenship are automatically suspended. On his return to the community their restoration may require positive action on his part, and there is room for doubt that this action is frequently taken. The statutory requirements call for automatic restoration of the patient's citizenship if he is discharged as recovered. If he recovers at any subsequent time he may apply to the court for their restoration.¹ Of the 71 replies received to the Alienist's inquiry as to the court's practice in this restoration, only 24 courts indicated that this automatic action was taken. Thirty courts waited for an application for restoration by the patient; it was not clear from the replies whether such application was not also required from a recovered patient in these courts. Two courts used a jury to make this decision. Ten courts took no action, 4 replies were not clear, and 3 courts failed to reply.

These replies suggest considerable confusion in the practice of restoration of citizenship. The matter is complicated by the small number of patients who are discharged as recovered; it is further confused by the large number which are discharged as "without psychosis," a group for whom the law makes no provision and whose citizenship status is in doubt. It would appear that most courts wait for the patient to take action; if he fails to do so his citizenship remains suspended.

There is little inducement for the patient to take this

¹Revised Statutes, 1937, c. 85, sec. 18.

necessary action. In some cases he may value his rights of citizenship lightly and have no interest in their restoration. Where he has such an interest, the prospect of another court appearance to apply for their restoration is a real deterrent. His commitment experience with the court and its related officers was probably a painful one. Even when recovered he hesitates to refresh these memories by repeating a similar process. And where jury trial is required the deterrent is almost complete.

This negative attitude of the community on the restoration of citizenship, expressed in the law and through the court procedure, calls for revision in theory and practice. Citizenship is properly suspended during a period of mental illness, but should be promptly restored on proof of recovery. The present practice of continued deprivation is rooted again in stigma--the patient once mentally ill remains under suspicion, and on him is placed the burden of proof to re-establish his competency. With community clinics available, a statement by the clinic that the patient is again mentally competent should be the only requirement for restoration of citizenship. And the act of restoration might well be done positively, as a concluding step in the process of recovery, having a genuine significance as the official recognition of his return to health, and welcoming his future participation in the public life of the community. Such an official restoration, positively executed, would have definite values both as therapy and in the promotion of constructive citizenship in patient and community alike.

The restoration of the patient's property through discharge of a conservator presents a similar situation. No data are available as to the number of conservators appointed each year; undoubtedly the number is only a fraction of the total number of patients committed; the problem is quantitatively a smaller one. If a patient has property he would presumably have more incentive to recover control of it on his recovery. Again, however, the factors of stigma and prejudice enter the situation, and he is handicapped in the process. The clinic is also in a position to render him timely assistance for this purpose.

For paroled patients, out-patient clinics are available at seven of the eight hospitals, and at eleven other points in the state, served by the eight hospitals. The clinics held at

the institutions have limitations in that they can draw only from a limited area adjacent to the hospital because of factors of distance and the expense of transportation to the paroled patient. Then, too, many patients or their families are unwilling to return to the institution after discharge. Despite considerate treatment they prefer to consider the period of hospitalization a closed incident, and dislike to return for follow-up care. These factors restrict the utility of the hospital as an out-patient facility.

Community clinics are provided in eleven different cities. In Chicago, five weekly clinics are conducted at two separate points, staffed by physicians from the four northern hospitals. Downstate, ten monthly clinics are held in ten different cities, staffed by physicians from five different hospitals. These clinics, held at a place apart from the hospital, and in centers of population, avoid the limitations of the hospital clinic, and are an important beginning in bringing the hospital to the patient. They are doing valuable work, but their number is few and they reach only a fraction of the total number of discharged patients. The follow-up of paroled patients by the social workers reaches additional patients, but this number again is small, being only one-fifth of the total patients discharged in recent years.¹ In view of the large numbers of former patients in the community and of their continuing needs for service, enlarged clinic service is imperative.

¹See Table 14. Many of these patients are also duplicated in the count of clinic attendance.

CHAPTER XI

THE FACILITIES IN COOK COUNTY

The City of Chicago lies wholly within Cook County; much of the surrounding metropolitan area is also within the county limits. In 1930, Cook County had a population of some 3,982,000 persons, or 52 per cent of the total population of the state. This metropolitan area is for the most part solidly built up and densely packed with people; for this large population, there is a set of local services for the care of the mentally ill. The public services under county direction include the Psychopathic Hospital and the Oak Forest Institutions. The State Department of Public Welfare operates the Chicago State Hospital, four parole clinics for Cook County patients on parole from the several state hospitals, and the Psychiatric Institute in the Illinois Research Hospitals. Out-patient clinical facilities are available in a number of medical centers and dispensaries in the city, as are a limited number of beds for mental patients in several general hospitals.

Examining first these clinical facilities for the early examination, diagnosis, and care of patients with mental illness, it is found that in the city there are nine out-patient clinics and dispensaries offering psychiatric service. With four of these clinics, the psychiatric service is a recent addition, having been added since 1932. At that time, under the agreement between the Department and the medical schools in Chicago, the schools agreed to provide out-patient services in psychiatry, both as community resources for treatment and for teaching devices in psychiatry for their students. All of these clinics have a general social service in connection; only four have psychiatric social service as an integral part of the clinic's operation. No information is available on the volume of service which these clinics render. In most of them only a nominal fee is charged; twenty-five cents a visit is a usual amount.

Chicago is abundantly served by physicians. The American

Medical Directory shows that in 1938, a total number of 6,800 physicians were practising in the city. Listed as specialists in nervous and mental diseases were 72 physicians; of this number, 61 were in private practice and 11 were in institutional or other positions, not engaged in private practice.¹

The earlier comments with respect to the general practitioner outside the city of Chicago have validity for the Chicago physician. Living in the city, he would appear to have better opportunities to become informed about mental disease; whether he does so or not is not known. He also has the advantage of consultation service from a specialist in psychiatry; such service is a benefit for persons in the upper third of the population who have sufficient income to pay a specialist's fee, as more competent diagnosis and treatment is thus made available to them.² For most of the population, however, psychiatric service, if it is to be obtained at all, must be had from dispensaries and clinics which offer free service or make only a nominal charge. The strongest evidence that there are still too few of these clinics to meet the needs of this large metropolitan area is to be found in the fact that of all the patients admitted to the Psychopathic Hospital each year, only a small number have been receiving any form of psychiatric therapy from specialists or clinics. In Cook County, as in the state, the disease becomes full blown before the patient receives proper attention. There is evident need of increased out-patient clinical services.

The great clearing house for the mentally ill in Cook County is the Psychopathic Hospital. Through its doors pass a steadily increasing stream of mentally ill persons, reaching a new high of some 6,200 patients in the year 1938. Some 120 patients per week have to be admitted, observed, diagnosed, and disposed of, all within the ten days' time permitted by the law for temporary observation period.³

This busy institution was opened on its present site in 1916, with substantially its present plant. Since that time

¹American Medical Directory, 1938, p. 210.

²Fees of psychiatrist in private practice range from a minimum of \$5.00 per visit upwards.

³Revised Statutes, 1937, c. 85, sec. 2.

there have been added a larger medical staff, more equipment for therapy, and an active social service department; however its procedures and clearing house function remain substantially unchanged. An examination of the place and work of this key unit of Cook County services is essential to an understanding of the County services.

The institution is housed in a squat, drab, red-brick building at Polk and Wood Streets, at the southeast corner of the Cook County Hospital buildings. Its five floors are heavily utilized, the first for offices, courtrooms, and admitting wards; the second, third, and fourth floors are wards and related services; the fifth floor is reserved for neurological patients. Its location directly on the street, together with its forbidding appearance, present a bare, custodial aspect that must affect patient and relative alike as initially discouraging and unfavorable to therapy. Its situation and appearance are in sharp contrast to the attractiveness of the various state hospitals.

The hospital has a rated capacity of 165 beds. This capacity is regularly exceeded by the steadily increasing patient load, so that at the peak of the weekly cycle beds have to be set up in corridors and day rooms. Its work revolves around this weekly cycle, based on "court days" on Wednesday and Thursday of each week. Patients are admitted at any time, but court hearings for commitment are limited to these two days. Consequently the weekly population increases to a maximum on Thursday, decreases until Sunday with the transfer and discharge of patients, when it again starts to build up. This weekly cycle is a practice of many years' standing, and is based on the court's convenience in moving its staff of clerks and bailiffs to the hospital for the hearing and commitment of the large number of patients. The administration and efficiency of the hospital thus revolve around the court's convenience.

Since the hospital is for observation purposes, the admission process is almost wholly by court warrant. This process is described in a previous study as follows:

The routine method of admission is to obtain a certificate from a doctor stating that the patient is insane. This certificate is taken to the County Building where a writ is obtained from the County Clerk for committing the case to the Psychopathic Hospital. If the patient is greatly disturbed,

he is frequently admitted as an emergency case and a writ is obtained later. Patients who have been arrested are brought to the Psychopathic Hospital from the various police stations or the County Jail, usually on the recommendation of the Director of the psychopathic Laboratory of the Municipal Court. Sometimes the police bring the patient directly to the Psychopathic Hospital if the patient is greatly disturbed or confused. Patients on parole from any of the state hospitals may be brought to the Psychopathic Hospital and returned to the state institutions.¹

Additionally, a very few patients are admitted voluntarily by the Superintendent, either for examination or for subsequent transfer to a state hospital for treatment. Voluntary admissions are purposely restricted, however, because of the lack of space and treatment facilities for the large number of court-committed patients.

The purpose of the Psychopathic Hospital is the observation of the patient so that the court may make disposition; it takes the place of the medical commission of the other counties. Two physicians from the hospital act as the Commission for the court. By law, the period of observation is limited to ten days; the average length of stay in the hospital is actually six days. This period allows only for examination and superficial treatment--diagnostic tests, continuous baths and packs for the reduction of disturbed conditions, special feedings and diets for resistive or physically reduced patients, and other interim measures. Long time treatments are left to the state hospitals; the Psychopathic Hospital makes a diagnostic determination, and sees that the patient is able to be transferred. In a few cases of doubtful diagnoses, the commitment can be renewed for a second or even a third ten-day period. The hospital's clearing house function is predominant; the stream of patients keeps pouring in; other patients must be presented to the court and gotten out to make room for the new admissions.

Court days are Wednesday and Thursday. A branch of the County Court of Cook County comes to the hospital, and is installed in the court rooms provided for that purpose. From 50 to 100 patients are disposed of in a morning's session of three

¹Lera Amlingmeyer, "A Case Study of 104 Patients Discharged from the Cook County Psychopathic Hospital" (Unpublished Master's thesis, University of Chicago, 1933), p. 6.

hours. Bedfast or disturbed patients are seen in the wards; ambulatory patients are presented individually before the judge, who is advised of the hospital's recommendation by the staff physicians who sit beside him. Patients committed to the state hospitals are transferred by bus on the same day or the following day. Discharged patients are free to leave the hospital following the court hearing.

Clerical procedures and the collection of court costs are handled in an adjoining room by the staff of court clerks and bailiffs. Court fees are set at \$10.00 for a first commitment and \$2.00 for a recommitment. An additional transportation fee of \$10.00 is charged for patients transferred to Elgin, Manteno, or Kankakee State Hospitals; the fee is \$3.00 to Chicago State Hospital. The decision of the family's ability to pay these large fees rests with the bailiff. Demand for fees is made to the relatives of each patient; to have the costs remitted, the relative must show his inability to pay. Relatives whose inability to pay has been previously determined by the social service department are advised by it to state their inability to pay to the bailiff; the discretion and the decision to waive the fee, however, remain in the hands of the bailiff.

It has become the practice of the County Court of Cook County to use downstate judges to conduct the court at the Psychopathic Hospital. The great majority of the courts are presided over by an out-of-county judge; these judges vary from time to time. The reasons for this practice were not ascertained, but the practice itself is an interesting evidence of how lightly the County Court holds its responsibility in the matter of commitment. It has become a routine process which in its judgment can be as well discharged by outside judges. This attitude is a tacit acknowledgment of the facts. In view of the routine nature of the procedure and the complete dependence of the court on the opinion of the psychiatrist, the person of the judge makes little difference in the whole procedure. The decision on mental illness has become a medical one, to be properly decided by the physician, not the court. On this point Cook County experience agrees with downstate practice; both demonstrate that legal proceedings are no longer necessary for the protection of the patient. There remains the problem of devising an acceptable substitute.

The staff of the Psychopathic Hospital consists of the Superintendent, 4 assistant psychiatrists, 8 visiting psychiatrists, and 8 associate psychiatrists, a total medical staff of 21 psychiatrists. Lesser staff comprises 50 graduate nurses, 26 student nurses, 27 orderlies and attendants, and a social service department of 11 persons. Occupational therapy is conducted by a full time worker from the staff of the Cook County Hospital.

The movement of population through the hospital is indicated in Table 22. It will be noticed that of the separations

TABLE 22

COOK COUNTY PSYCHOPATHIC HOSPITAL
MOVEMENT OF POPULATION
YEAR ENDING NOVEMBER 30, 1938

	Number		Per Cent of Total Separations
Patients on the books at the beginning of the year.....		117	
Total admissions.....		6,182	
First admissions.....	4,547		
Re-admissions.....	1,635		
Total patients handled.....		6,299	<u>100.0</u>
Total separations.....		6,169	
Transfers to state and federal hospitals.....	4,830		78.0
Discharges.....	915		15.0
Committed to the care of relatives.....	297		5.0
Died.....	127		2.0
Patients on the books at the end of the year.....		130	

from the hospital, 78 per cent of the patients are committed to the state hospitals and 5 per cent are committed to the care of relatives or guardians. Discharges account for 15 per cent of the total number. A smaller number die in the hospital; they are often aged persons, or others brought in in advanced stages of physical reduction or disease.

The mental conditions met with show the usual diagnoses.

As might be expected in a large metropolitan community, alcoholic conditions are more frequent than is found in the state hospitals; many of these are conditions responding quickly to treatment and the patients are discharged.

TABLE 23

ADMISSIONS CLASSIFIED BY DIAGNOSIS
COOK COUNTY PSYCHOPATHIC HOSPITAL
YEAR ENDING NOVEMBER 30, 1938

Diagnosis	First Admissions	Re-Admissions	Total Admissions	Per Cent of Admissions with Psychosis
Total, all admissions...	4,547	1,635	6,182	
Total admissions with psychosis....	4,190	1,561	5,751	100
Dementia praecox.	1,152	559	1,711	30
Alcoholic.....	726	499	1,225	21
Senile.....	557	71	628	11
General paralysis and other syphilis c.n.s.	368	39	407	7
Cerebral arterio-sclerosis.....	305	48	353	6
Manic depressive.	101	76	177	3
All other.....	981	269	1,250	22
Total admissions without psychosis....	357	74	431	
Alcoholic.....	236	63	299	
All other.....	121	11	132	

For the 900 patients who are discharged each year, limited follow-up service is available. The hospital has no out-patient clinic service to which the patient can return. He can be referred to other clinics in the city, and frequently is so referred; whether he actually attends or not the hospital does not determine. The social service department refers some cases for follow-up to the nearby Psychiatric Clinic of Loyola University Medical School; this clinic has a co-operative relationship

with the hospital, having the same director, some of the same medical staff, and a social service department. However it has a limited capacity, and lacks the official status possessed (and sometimes needed) by the hospital in order to continue treatment.

The Social Service Department was established by the County Court in 1908, in order to secure information about the patient prior to commitment proceedings. In 1923, the department was taken over by the Illinois Training School for Nurses; on the organization of the Cook County School of Nursing in 1929, the department was transferred to it, where it has remained. The present staff consists of the Director, six case workers, and five clerical workers. The Director is a professionally trained and experienced case worker, and is also a graduate nurse. Because of the rapid turnover of patients in the hospital the department works under constant pressure. Its activities are indicated in the table below.

TABLE 24

STATISTICAL REPORT OF THE SOCIAL SERVICE DEPARTMENT
COOK COUNTY PSYCHOPATHIC HOSPITAL
FISCAL YEAR ENDING NOVEMBER 30, 1938

Total number of patients admitted to hospital	
Male	3,628
Female	<u>2,554</u> 6,182
Number of patients referred to Social Service	
(Ex-service patients	New 4,387
are not referred)	Old <u>1,385</u> 5,772
Number of histories completed	5,707
Number of histories sent to state hospitals	4,493
Number of incoming letters	2,309
(This does not include routine requests from social agencies)	
Number of outgoing letters	3,308
Number of patients sent to state hospitals	4,792
Number of patients discharged	1,212
Number of visits made into community, for social investigation	47
Summaries of histories sent to other agencies	
Social agencies	827
Medical (other than state hospitals)	151
Legal agencies	<u>161</u> 1,139
Supplementary histories secured from agencies	
Social agencies	917
Medical (other than state hospitals)	196
Legal agencies	91
Psychopathic laboratory (telephone)	<u>600</u> 1,804

Its chief activity is the securing of histories on committed patients. Because of the rush of admissions the physician has little time for this purpose. Hence, it has become the responsibility of the social service department to interview the patient and his relatives, to secure information from other social agencies, or to make a field investigation where necessary in order to compile a social history on the patient. Such a history is, of course, essential for purposes of diagnosis, commitment, and treatment. A copy of it accompanies the patient to the state hospital for the information of the state hospital physicians and social service department.

The department has also worked out co-operative arrangements with other social agencies in the city for the furnishing of certain necessary services to discharged patients. For families in which relief is necessary, an arrangement with the Chicago Relief Administration permits the furnishing of prompt assistance. Families in which case-work services would appear helpful are referred to the United Charities for this service. Hence although the department itself is not large enough to do follow-up work, certain services have been arranged for through existing agencies.

The deficiencies and needs of the Psychopathic Hospital are set out by the Superintendent in a recent report. These are principally the lack of treatment facilities, and the need of an out-patient service. On the former he comments:

Neither can [the hospital] maintain its position long if it remains purely a detention hospital. It must have some facilities, though these not be extensive, for the treatment of patients with acute mental disturbances. An unfortunate situation now exists which forces the stigma of adjudication of insanity and commitment to a state institution upon patients who would recover in a few weeks to one or two months if they were treated in the Psychopathic Hospital. Full recognition should be given to this fact and provision should be made for the necessary facilities.

In other words, the newer program of therapy must replace the older one of custody. For a metropolitan area of four million people, having only this one publicly operated facility for reception of the mentally ill, this request is surely a modest one. If the local authority is to undertake the functions of early diagnosis and treatment, then adequate equipment must be provided. A modified jail, with physicians and nurses added, does not meet

the need.

The second large need is for out-patient services. The Superintendent states:

Another function naturally belonging to the institution is an out-patient clinic service. With present personnel and quarters, we cannot undertake this function. We are forced to refer such work to other dispensaries, even though we know their facilities are also limited.¹

Again, this is a modest summary of a pressing need. The arguments for adequate out-patient service are worthy of much fuller presentation.

The successive reports of the Hospital show a steadily increasing patient load during the last five years. This load

TABLE 25

COOK COUNTY PSYCHOPATHIC HOSPITAL
ADMISSIONS BY YEARS SINCE 1934*

Year	Number of Admissions
1934	5,597
1935	5,591
1936	5,870
1937	6,127
1938	6,182

*Comparable figures prior to
1934 are not available.

now taxes its capacity of 165 beds. Few of these patients have had earlier psychiatric examination or treatment such as could be obtained from an out-patient clinic.² Had this service been easily available, numbers of these patients could receive treatment and continue living at home; admission to the hospital would be unnecessary. Hence its intake could be restricted to those patients

¹President of Board of Cook County Commissioners, Annual Message, 1938, p. 81, Report of the Superintendent of the Psychopathic Hospital.

²Treatment by a specialist in psychiatry is omitted in this discussion because the high cost of such treatment puts it beyond the reach of all but a small number of wealthy persons.

for whom hospital care is clearly advisable, and for these better care could be provided. The hospital would have the opportunity to do a better job.

Economic considerations support this point. The cost of institutional care is always high, even in custodial institutions. The per capita cost of care at the Psychopathic Hospital is not less than \$6.25 per day.¹ The average stay is six days, making the cost per patient some \$38.00 for the examination. This is a high figure for such limited service. No comparable figures are available for the cost of similar service in an out-patient clinic, but it is certainly only a fraction of the institutional cost; the practice of automatically herding all patients into an institution for examination is an expensive one. Moreover, it is wasteful because it is unnecessary for a considerable number of the patients. Cook County is paying a high cash price for its failure to provide modern clinical facilities for the mentally ill.

Hospitals for the treatment of physical illness have long since abandoned this expensive and unnecessary practice. Diagnosis is made in an out-patient clinic; the patient is hospitalized only where hospital therapy would clearly benefit his condition. While mental illness can never be an exact parallel because of the aspects of behavior involved, the treatment of mental illness has certainly advanced to the point where this differential treatment is possible and necessary. Out-patient clinics can diagnose and treat a considerable range and variety of mental illnesses; they are doing so satisfactorily in Chicago today, and have done so for years past. Cook County has made notable advances in medical care in other areas; it is now time that the field of mental illness be reviewed and that adequate facilities be provided to meet these pressing needs.

There is immediate need, then, for a large out-patient service for mental illness, publicly operated and free of cost to the patient, as an integral part of the Psychopathic Hospital services. It would allow for earlier examination and treatment of many patients, avoiding later institutionalization and commit-

¹Estimate supplied by Dr. Francis J. Gerty, Superintendent, October, 1939.

ment; long time care of many mildly chronic patients in the community, and follow-up of patients discharged from the Psychopathic Hospital and the state hospitals. Such a central clinical facility is in accord with modern practice everywhere; need and logic call for its creation in Cook County.¹

A realistic question presents itself at this point: Would there be advantages in state operation of the Psychopathic Hospital? This is an important question and deserves careful examination.

The proposal is not a new one. It was made by the first Director of the Department, and has been repeated by Mr. Brandon and Mr. Bowen. However, it has rested at the question stage.² No evidence was found that it had been raised or considered by county officials. It merits more adequate presentation and discussion.

The Department has a large stake in the facilities for mental health in Cook County. More than half the admissions to the state hospitals come from the metropolitan area, a number of some 5,000 patients annually. At least one-half of its appropriations for hospitals, or a sum of \$3,500,000 annually is expended for their care. It is therefore directly concerned that adequate services for prevention and early diagnosis and treatment be available in Cook County, in order that its own costs be kept at a minimum. No further justification is required to defend its lively interest in Cook County facilities.

In pursuance of this interest, it already operates a number of services within the county. The Chicago State Hospital cares for 4,700 patients; four state-operated parole clinics, staffed by physicians and social workers, offer extra-mural care

¹It is not the intention to imply that this clinic need necessarily be geographically centralized at one spot in the city. Presumably part of it would have to be connected with the Psychopathic Hospital, if it remains in its present location. (There are certainly arguments for moving it to a happier one.) But branch clinics could be established in other parts of the city; a north side clinic on the grounds of Chicago State Hospital, and one to serve the south side at some convenient location. These district clinics would possess advantages of reduced stigma, and of convenience to the area of service.

²Department of Public Welfare, Annual Report, 1931, p. 15, Report of the Director.

to former state hospital patients who are residents of the county. (It should be noted that they are also former patients of the Psychopathic Hospital.) The Psychiatric Institute of the Research and Educational Hospitals, adjacent to the Psychopathic Hospital, carries on an active program of treatment and research. The activities of these different state-operated services dovetail with that of the Psychopathic Hospital at numerous points; on the whole, an effective program of co-operation between the two authorities is maintained. But there are good reasons why the Department should operate the Psychopathic Hospital, more closely integrating it into the existing chain of services. Particularly valuable would be the organization of the large out-patient clinic (or a series of clinics) to serve for both the examination and the treatment of incipient disorders, and the follow-up of patients from Psychopathic Hospital and state hospitals alike.

Such a centralization of administration would permit better utilization of existing and future facilities. Patients could be readily classified as to their need of out-patient services, short-term hospitalization, long-term hospitalization, and post-institutional care. As a direct result, all these facilities could be more wisely and fully used, to the benefit of patient and authority alike. A more adequate research program would well center in the new Institute of Psychiatry and Neurology, extending the valuable beginnings which have been made in the Psychiatric Institute. At the moment, the Superintendent of the Psychopathic Hospital is requesting larger facilities for institutional care, out-patient service, and for research. While the first two services are immediately necessary, the third is a less urgent need. In its consideration of these requests, the Board of Cook County Commissioners could well give serious attention to the larger possibilities of a centralized program.

A centralization of all responsibility for the care of the mentally ill in the state department would follow the best thinking on the practice of public welfare administration. The function is a well-defined one; for a century the state has accepted it as a state responsibility. During the century the state has widened the extent of its responsibility into all the phases of mental health--prevention, early treatment, institutional therapy, after-care, and research. In that time the county has taken

no steps to extend its services beyond those necessary for commitment--its sole original responsibility. The case seems clear, then, for continued expansion of services under state direction; its larger resources and wider experience in the field justify its leadership and control.

It is also pertinent to point out that in no county other than Cook County have any local facilities developed. In Cook County the Psychopathic Hospital has developed as a logical service of the County Hospital on the one hand, as part of its local responsibility for care of the indigent sick under the Poor Law,¹ and a convenience for mass court commitment on the other. Neither of these reasons needs affect state operation of the hospital; the necessary co-operative and administrative arrangements can be worked out with these two authorities, continuing on the present basis. It is significant that in several other states, the state operates a metropolitan unit such as is proposed for Cook County. No better example could be quoted than that of Boston Psychopathic Hospital, with its excellent hospital facilities and related outpatient clinics; Illinois could well aim to attain its standards and distinction.

The Cook County authorities may demur at the proposal because of the fear of interruption of the teaching facilities which the Psychopathic Hospital now offers to the medical schools. The County Hospital has attained world-wide distinction for this teaching activity; its directors may hesitate to endanger it by the alteration of even one service. Such a fear, however, would be groundless. An enlarged Psychopathic Hospital and related clinics, under state control, would undoubtedly continue to be an active teaching center. The state has seen the necessity for this service in its own hospitals, and has provided in them for medical training in both clinical and research services. Such an enlarged center would provide much more teaching material than any one medical school could use. There would be ample cases for all the existing schools in Chicago (if all cared to use it); a co-operative arrangement for equitable use of its facilities could be easily worked out. For proof of its interest, one has only to

¹See S. P. Breckinridge, The Illinois Poor Law and Its Administration (Chicago: University of Chicago Press, 1938), pp. 128 ff.

consider the efforts which the Department has made in securing the co-operation of the medical schools in the provision of more adequate teaching work and clinical services in psychiatry. In turn, the Department is under contract to make available to the schools the resources of its state hospitals and other services for teaching purposes. These present contractual arrangements could easily be extended to include co-operative use of the Psychopathic Hospital and clinics if these were state operated. The need for enlarged facilities for the treatment of mental illness in Chicago is agreed on by all parties; a co-operative spirit has been demonstrated in providing them. It can well be extended to cover the present proposal.

The advantages mentioned have been set out in some detail. They can be summarized around the central purpose of any mental health authority--the provision of the best possible services for the treatment of the mentally ill. This study indicates at numerous points the conflicts arising in the present state of transition between the older concept of custody and the newer one of therapy. Recent scientific advances are hastening the movement toward a completely therapeutic viewpoint. In this process larger administrative units tend to replace smaller ones; the appearance on the horizon of publicly operated medical services will accelerate the change. It would appear that a centralized authority for mental health, serving all the citizens of the state, would best discharge this therapeutic function. If so, it should administer the very extensive services in Cook County; those which now exist, and those which are additionally needed.

One reservation needs to be made at this point: the wisdom of making this change under the present organization of the state Department of Public Welfare is to be questioned. As pointed out earlier, the Department as an administrative instrument is at present of unwieldy size and handicapped by serious structural weaknesses. To advocate any extension of its already heavy program under its existing structure would be unwise. The changes proposed should await a reconstructed Department; desirably a new Department of Mental Health, or at least an administrative unit which permits more effective assumption and discharge of responsibility than does the existing Department. Its load is already impossibly heavy.

The Oak Forest Institutions

One other facility in Cook County should be mentioned; this is the Oak Forest Institutions. This large group of institutions is located at Oak Forest in the southwest part of the county, twenty miles from Chicago. First occupied in 1912, when it replaced the old Cook County Almshouse in the City of Chicago, it has been enlarged from time to time, and on June 1, 1939, cared for some 3,500 patients; included in this number are some 430 tuberculosis patients in a nearby institution.¹ The majority of these patients require infirmary care of some degree; some 60 per cent are aged. One-third of the population are bedfast or "marginally mental" patients; the other two-thirds are ambulatory patients, requiring various degrees of attention or assistance. Of the total, 820 were classed as "Ambulatory, able to do chores." Many cases of chronic illness, physical defect, mental defect, and borderline mental disease are present in the population.

The group classified as "Untidy and marginally mental" contained 420 patients; 215 men and 205 women. The predominant diagnoses are senile, arteriosclerosis, and mentally deficient. The quality of care received is comparable to that offered by a state hospital. However, there is no psychiatrist on the staff to care for this considerable number of mental patients, nor is any attempt made at differential treatment; the patients receive only the "average" care of a large public infirmary of this kind.

All Oak Forest patients are admitted through the Cook County Bureau of Public Welfare, Oak Forest Service. No commitably insane persons are admitted, though a small number of such admissions occur where the condition is not pronounced. When a patient becomes too difficult for care at Oak Forest, he is transferred to the Psychopathic Hospital and from there committed to a state hospital. Nor does Oak Forest admit any patient on parole from a state hospital; however, it will admit a former patient who has been certified as recovered. A limited case-work service is provided for patients who have been discharged from the Insti-

¹These data on Oak Forest have been obtained from reports of the institution in the Annual Message of the President of the Board of Cook County Commissioners, supplemented by correspondence with Mr. Otto Wander, Supervisor of the Oak Forest Service of the Cook County Bureau of Public Welfare.

tutions.

Cook County, then, provides infirmary care for some 400 "marginally mental" patients in the large Oak Forest Institutions. The surroundings and the standards of care are similar to those of the large state hospital. While the disadvantages of institutionalization are less marked for this age group, many of them are pertinent. The comments made earlier on the state hospitals are also applicable here. Congregate institutional care is resorted to as the "easiest" provision to make; to it individual needs and backgrounds are subordinated. As with the state institutions, however, the easiest way soon becomes the most expensive way. When the whole picture is viewed, the purported "economies" are often only shallow claims; the costs, socially and financially, are borne in heavier measure by the patients and by the community. Programs of diversified care are as necessary here as in the state hospitals.

CONCLUSIONS

From this study come many conclusions. They relate primarily to a few main topics--the structural weakness of the state department as an administrative situation caused by the patronage system, the predominance of custodial philosophy and practice in the hospitals, the need of revision of the commitment laws, and, finally, the great need of interpretation about mental disorder in order that the heavy cloud of fear and stigma which now darkens the whole field may be dissipated. These points will be considered in turn.

The weaknesses of the Department, as set out in Chapter I, are confirmed by several other examinations of its work. These are: (a) a study of penal and parole administration by the Illinois Prison Inquiry Commission in 1936; (b) a study of the general reorganization of the Department made by the Doering Commission in 1935; and (c) a study made of the Department by the Illinois Council on Public Assistance and Employment in 1938. The findings and recommendations of these studies merit consideration as related to those of the present study.

The Illinois Prison Inquiry Commission¹ (the Schlarman Commission and Report) was appointed by Governor Horner following a fatal altercation between two prisoners at the Stateville Branch of the Illinois State Penitentiary in 1936. It was asked to study and report on the penal and parole functions of the Department; the bulk of its work was done by Mr. Henry Barrett Chamberlain, of the Chicago Crime Commission. Its major recommendation is for the consolidation into one administrative unit of all the work of probation, penal institutions, parole, and rehabilitation of offenders in the state. Such of these activities as are now under the Department would be removed from it and placed under a separate administrative unit, the Illinois Board of Prison Administration. This would be a paid administrative Board of five members, appointed by the Governor for overlapping

¹The Illinois Prison Inquiry Commission, The Prison System in Illinois (Springfield, 1937).

terms of fifteen years. It would have full control over the selection of personnel for the services which it would direct.

Detailed comment on this proposal is not in place in the present study. The question can be raised, however, of the wisdom of returning the administration of this large public welfare function to a paid administrative board; such boards have not proved to be effective administrative agencies and are being replaced by non-administrative boards or single executives. Particularly is the recommendation to be questioned for Illinois, with its departmental form of administration under the Civil Administrative Code. Significant for the present study, however, is the finding that in the Commission's opinion, the correctional functions could be more effectively administered by a separate authority, removed from the Department of Public Welfare. The recommendation is partly based on findings parallel to those of this study--that the Department is too large and unwieldy and its structural skeleton too weak, properly to administer all the services at present within it.

The "Doering Report" was the work of the Governor's Commission on the Relief Problem,¹ appointed in 1935 by Governor Horner at the request of the Illinois Emergency Relief Commission; it was asked to study the question of a state agency for the long-time administration of relief and public assistance in the state, and the relationship of the Department of Public Welfare to these new services. Its recommendations called for expansion of the present state Department to include the administration of relief and public assistance. For this purpose its structure, however, was to be changed, control being vested in a Director appointed by an unpaid, non-political State Board of Public Welfare of seven persons. The Board was to determine the necessary reorganization of the Department to carry its new functions; the Commission suggested five divisions for this purpose; Child Welfare, Corrections, Mental Hygiene, Care for the Handicapped, and Public Assistance. On presentation of its report Governor Horner vigorously rejected the recommendation for a State Board of Public Welfare as breaking up the cabinet form of government provided by

¹Governor's Commission of the Relief Problem, Report (Springfield, 1935).

the Civil Administrative Code of 1917. No action was taken on its other recommendations. The report is of interest to this study because of its divisioning of the Department on a functional basis; mental health was designated as one division, though of course remaining under the central structure of the Department.

The Illinois Council on Public Assistance and Employment¹ was appointed by Governor Horner in 1938, again with the interest of the Illinois Emergency Relief Commission. It secured the assistance of the American Public Welfare Association in making a study of the Department, together with the developments needed for administration of public assistance throughout the state. Its recommendations called for the expansion of the Department to include the administration of relief and public assistance, together with organization of county departments of public welfare for the same purpose. Administrative authority in the state Department was to continue in the Director; he was to be aided by a Deputy-director, who would assist in co-ordinating the various functions and activities of the Department. Advisory service was planned for the Department through an Advisory Board of lay citizens, appointed by the Governor for overlapping terms and the provision for technical advisory committees, appointed by the Director, for assistance on specialized problems.

The work of the Department was to be reorganized under three main functional divisions--Assistance and Service, Corrections, and Mental Hygiene. Additional staff services were to be supplied by four technical services, Finance and Management, Research and Statistics, Personnel and Training, and Procedures and Systems. The Department was also to establish regional offices at certain points in the state the better to supervise the work of the county welfare departments.

Of these studies, one concerned only corrections, and two looked primarily to including the administration of relief and public assistance within the Department; none was directly interested in the Department's largest responsibility, the care of the mentally ill. In considering this function, the present study would go farther than these recommendations. It would recommend

¹The Illinois Council on Public Assistance and Employment, State and Local Public Assistance Administration in Illinois (Springfield, 1938).

that a new state Department of Mental Health should be created, to have charge of the operation of all publicly operated mental institutions and services for mental health in Illinois, including the institutions and services for the care of the mentally deficient. There are sound arguments for the creation of a separate department.

Mental institutions have always been the major activity of the present Department. During its life they have increased steadily in number and size. In these two decades, also, such advances have been made in the knowledge of mental disorder and its treatment that the practice of mental health administration has become a well defined and positively minded service; no longer is it "one of the state charities." In Illinois, it has suffered heavily in the past from this lack of recognition, and now deserves it.

Moreover, its services are so large that a separate department is required for their proper administration. In terms of expenditures, number of hospitals, number of patients, size of staff, and importance of related services such as clinics, social service, and research, the mental services justify a separate department with a responsible director; his department will continue to be one of the largest in the state government. Mere re-shifting of services in the present omnibus Department of Public Welfare will not achieve the end required; major surgery is necessary to set up a wholly separate department.

A supporting reason is that even within a new Department of Mental Health, good salaries will have to be paid at the executive levels to secure competent personnel. The salary of the Director will have to be equal to or higher than the present salary of the Director of Public Welfare. With all the hierarchy of officials that a reorganized Department of Public Welfare would require, it would be impossible to have a salary for a division head for mental hygiene large enough to attract a sufficiently competent and qualified person. Moreover, it would be difficult to secure such a person if he was to be made responsible to a non-medical director of the Department. The post requires a Director of Mental Health with responsible control over his own department; only a person of such a caliber should be entrusted with such responsibility.

These arguments apply to the present situation; on looking forward additional necessity is seen for a separate department. The hospitals have grown steadily during the past two decades; they will continue to grow for some time into the future. With increasing knowledge about mental disorder and the reduction of stigma, it may be expected and desired that a larger number of persons will seek early attention for mental illness. Milder cases can be treated at out-patient clinics, but hospitalization will also have to be increasingly provided. From whatever angle the prospect may be viewed, there will be need for enlarged services, carefully co-ordinated and skillfully directed, to provide adequate care for mental illness in the state. Such an expanded system of facilities calls for a separate department, headed by a competent professional director.

For such an important department, the qualifications of the Director are of basic importance. He should be a psychiatrist, a diplomate of the American Board of Psychiatry and Neurology or the equivalent, who has had at least five years successful experience as a managing officer in mental hospital administration. Choice of such a director should not be limited to Illinois; the importance of the post indicates that the nation is not too large a recruiting ground.

The question of security of tenure is a critical one. Can a director of proper caliber be secured when he is assured only a maximum period of four years tenure by the appointing Governor? This short term of office has been the curse of past administrations and has prevented sound long-time planning and administration. Under the cabinet system of government in effect in Illinois, the incoming Governor names the directors of Code Departments and they then constitute his cabinet. The justification for this practice is that these appointees, of his own selection and viewpoint, will work harmoniously with him and his policies. During the period studied two governors have succeeded themselves, affording longer periods of continuity of control. There is no assurance, however, that future practice will afford such chance security to departmental administrators.

In fact, the security offered by an administration's second term is more apparent than real. In both the instances of this twenty-year period, the political party supporting the ad-

ministration was itself torn by internal strife, strife at least as bitter and disruptive as that between the opposing political parties. Continuance in office is not necessarily evidence of the party's strong leadership or consistent purpose; it may be mere political chance, and offers little security to appointees of the first administration. Illinois, with its regrettable upstate-downstate antipathies and its all-but-unchangeable constitution, seems likely to perpetuate these characteristics of its political parties. Hence the position of departmental directors will continue to lack any real security.

In view of these considerations, efforts for security must be made along the lines of development of a tradition of continuance in office during satisfactory performance for those directors of departments in which experience plays an important rôle. There is evidence that such a tradition is beginning in Illinois; the cases of Mr. Brandon and Mr. Bowen were cited earlier in support of it.

A second factor making for stability is the extension of merit appointments. With the termination of the Buck Amendment, more security for civil service employees is restored. By the restoration of civil service protection to personnel under it, and extension of the civil service law to cover all posts below that of Director, an improved personnel can be built up in the Department. If this goal can be achieved, then the further application of the principle of merit selection to the post of Director can be made, offering assurance to a qualified Director that he would probably be retained in office despite changes of administration.

A third factor, probably operating in the near future, will be the increased protection afforded by the administration of the federal grants-in-aid. The Wagner Bill¹ makes provision for such grants to the states for construction of mental hospitals and the extension of facilities for the treatment of mental illness. The considerable sums designated for these purposes would permit substantial assistance to any state; such grants

¹"A Bill to provide for the general welfare by enabling the several states to make more adequate provision for the public health" etc. (February 28, 1939), Senate Bill 1620, U. S. Seventy-sixth Congress, 1st Sess.

would be a strong inducement to Illinois to participate in the program. To do so, however, certain minimum standards of state service would undoubtedly be required by the federal authority designated to administer this phase of the measure, the United States Public Health Service. These standards would call for competent medical staff, including a professional director of the Department, and qualified medical officers. Granting participation by the State, the federal authority would therefore have supervisory powers over its program, exercised through financial control. Moves by political forces to change personnel, including the removal of a competent Director, would therefore be met by the prospect of loss of federal assistance, which prospect might act as a deterrent to the change. This type of federal supervision has already operated in Illinois to effect the reorganization of administration of Old Age Assistance on a merit basis. It is recognized that the care of the mentally ill has much less political importance than has Old Age Assistance; nevertheless, the substantial sums involved would be a strong inducement to enter the program, and, once the program was in progress, their threatened withdrawal would be an effective influence in retaining competent personnel.

Related to this point is the acceptance by the state of an increasing amount of federal supervision with respect to maintenance of standards in other welfare fields; several factors are operative toward this end. The recent amendment to the Social Security Act,¹ awarding the Social Security Board more power in the determination and enforcement of administrative standards, will operate to raise standards of personnel in state programs. Similar will be the effect of the increase to 50 per cent of the share of costs of administration of state programs which the federal government may pay, allowing it larger voice in the standards of state administration. It is recognized that the State of Illinois has been slow in providing the benefits of the Social Security Act for its citizens, but it may be expected that this condition will eventually be changed. To the extent that the state government has to meet federal standards in an increasing number of social services, it will be the more ready to accept

¹H.R. 6635, approved August 10, 1939.

the merit principle in all public welfare services and hence to abide by it for the Department of Mental Health.

In the heavy responsibilities of operating his department, the Director should have the assistance of an Advisory Board and of special technical committees. The Advisory Board, its members appointed by the Governor for overlapping terms, should be made up of outstanding lay persons of the state who have some understanding of, and interest in, the work of the Department. It would assist the Director in the formulations of policies, the important process of interpretation, and afford general advisory services. It would also afford additional security to the Director in case of political attack or pressure. When allowed to function, the present Board of Public Welfare Commissioners has performed some useful service in this capacity; a well-selected advisory board, similar in purpose, would have an important function in the new Department.

Special advisory committees on technical aspects of the Department's work could also be of assistance to the Director. These could be appointed as need existed; they would advise him on the special phases or problems of administration. These technical committees would have the double advantage of bringing to the Director the best knowledge and skill available in the state, and of giving these outstanding persons in various professional fields an understanding and appreciation of the many and important problems faced by a large state department in its work. This process would not only have a valuable interpretive aspect, but would promote the very desirable practice of encouraging the participation of skilled persons in studying and solving the problems of government, through contributions in their particular fields. Such a development would help to restore the lowered prestige of state government in Illinois, and to contribute to its intelligent functioning.

The necessity for a thoroughgoing application of the Civil Service Act has been pointed out; such an application of the merit principle underlies the successful operation of a new Department or any improvements in the present one. Several points are worth specific mention. At the top, all the executive posts in the central departmental structure should be filled by merit selection, as many as possible by promotion from below. The position of

Managing Officer should be filled by promotion, removing the present anachronism of the direction of a merit-appointed medical staff by a non-merit selected Managing Officer.

To attract and retain a competent medical staff, a substantial program of improvement will have to be followed. The recent salary increases are a first step, but they are only a beginning of the necessary measures. A much larger staff is essential, with a better balance between senior and junior physicians than at present, desirably obtained by promotion from the present junior ranks. A beginning has been made toward the appointment of a clinical director in every hospital. His stimulation of better clinical practice will need to be supported by more adequate equipment for examination and therapy, libraries, autopsies, improved recording, and much increased social service facilities. Opportunities for professional recognition through participation in research, the preparation of papers, and leaves of absence for study will contribute; the improvement of such basic services as housing and food should hardly require comment.

At the attendant level two large changes are necessary: the merit selection of personnel and the provision of training courses. The two provisions are mutually dependent; good personnel is unlikely to apply for employment without some prospect of interesting work and advancement; attempts at training are wasted on unfit attendant material. Both provisions are necessary if the whole level of therapy in the state hospitals is to be raised above its present irregular minimum. There is little point in spending increased sums for the improvement of the medical staff if the attendants through which the physicians must work remain an ignorant and apathetic group. The great majority of patients will receive little better care than that which the average attendant can give; until he becomes an interested and competent person therapy will languish.

For all hospital personnel, three additional provisions are necessary; these are, security against the results of accident or injury in the course of their employment, a retirement plan, and more satisfactory arrangements for housing. The irresponsibility of the state Department for injuries to employees in the course of duty should be ended; all hospital employees, or at least physicians, nurses, and attendants, should be brought under

the Illinois Workmen's Compensation Act. It is a simple matter for the Department to supply medical care for its injured employees; it now does so. To this medical care should be added the cash benefits for loss of earnings due to the injury, whether of temporary or permanent duration. The state as an employer should no longer avoid this basic responsibility to its own employees.

The advantages of a retirement plan do not call for detailed presentation. The responsibility of government for such provision for its employees is acknowledged and practiced by the federal government, and many state and local governments. The hospital employee, whether medical or attendant, has a moderate salary and limited opportunities for advancement; his salary is too meagre to allow any private provision for his later years. In view of the many factors breeding dissatisfaction in his outlook, one of the simplest and most fundamental to remedy is this question of retirement. A sound plan would pay dividends in terms of increased interest and stability of employees.

The influence of institutional housing on employees' attitudes has been discussed. The present housing provision reflects the institutional thinking so prevalent in the Department--since space is being provided for thousands of patients, why not add a few more rooms or buildings for employees? The function of housing and its importance to the relaxation and morale of the employee has been given scant consideration. There is no more reason why the state should provide housing for hospital employees than for clerical staff at Springfield or any other group of state employees. And there are many good reasons why the hospital employee should be housed altogether apart from the hospital.¹

These reasons justify serious consideration of the abandonment of the policy of housing employees in the institutional buildings on the institutional grounds. The employees, medical and attendant, should be permitted and encouraged to live in the community, away from the institution, as do the employees of any other employer. Because of the large number of employees now housed in the hospitals, this change would have to be a gradual one. For the encouragement of it, the Department might well give thought to the erection of modern housing for married employees,

¹Cf. p. 88.

apart from the hospital and adjacent to the larger community. Such a facility, rented to employees at cost, would encourage the employment of married employees and allow present single employees to marry; both results would favor security, stabilization, and enhance the satisfaction of the employee with his vocational outlook.

The present state and needs of the hospitals have been carefully studied by the Chicago Institute of Medicine; their findings were presented earlier, and with them the present study is in strong agreement. As therapeutic institutions, they have large needs of more and better trained medical staff, and more adequate equipment for their use. In almost every area improvement can be made--the safety and attractiveness of the wards, the serving of food, the provision of more occupational and social therapy, a large increase in the number of social workers. It is noteworthy, too, that marked variation occurs among the several hospitals, indicating a lack of central supervision from the Department, which has the responsibility for seeing that at least adequate minimums of service are available to all patients in its care.

The findings of the present study, broader in scope, suggest several additional needs in the hospital service. The first of these is concerned directly with hospital administration; it is the need for specific organization or practices within each hospital for moving the patient out when sufficiently improved or recovered. The need for such a device has been mentioned at several points in the body of the study; it is properly re-emphasized here.

The hospitals, with their background of custody, their detachment from the community, and their concentration on the process of diagnosis, accumulate many patients who are mentally able to be discharged, but who remain in the institution. While the depression has greatly increased the difficulties in returning the patient to his family and community, this accumulation of improved patients was present long before the depression. Moreover, with the advent of new social services and forms of public assistance in the community, the hospitals should be taking much more advantage of these helpful services than they are yet doing. The continuance of "the depression" is the stronger reason for active

services of this kind; a tremendous field is calling for their best efforts.

Answers have already been given to this problem in different forms by at least two of the hospitals, Elgin and Kankakee. The former holds regular improvement and parole conferences to consider the progress and condition of the patients relative to discharge. These are useful devices, but tend to favor the newly admitted or recovering patient, as against the older patient who is no longer medically interesting, but whose parole difficulties may be more acute. At Kankakee, it becomes a responsibility of the social service department to follow every admitted patient through to discharge, parole, or definite determination of unfitness for either. Under this plan, no patient can get lost or forgotten; the hospital assumes as much responsibility for getting him out as for diagnosing and treating him on admission; as strong an effort is directed against the solution of social factors blocking his discharge as against somatic factors delaying the improvement of his physical or mental condition. This is the truly therapeutic viewpoint of rehabilitation; not only must the patient be restored to health, but he must be restored to family and community life. Only then is the job of the mental hospital completed.

The second change indicated is for the incorporation of the Cook County Psychopathic Hospital into the system of state hospital services. The arguments for this move have been fully set out; it is a major step in carrying out the essential integration of existing services under a state Department of Mental Health. In the long development of this broadening state responsibility, the state in 1912 took over from Cook County the former Cook County Asylum; the time has arrived to complete the transfer of the final unit to the state service, that of the Psychopathic Hospital.

A phase of this large question of the state services for mental health which has received far too little attention in Illinois is the use of devices other than large custodial institutions for the care of mental patients. Practice in the United States has run almost wholly to the care of patients in large custodial units ranging in size up to 5,000 or even more beds. These massive storehouses are in sharp contrast to the use of

smaller institutions in Europe, and the variety of non-institutional devices which are also in active use abroad. American practice is to be explained (but not justified) by a conjunction of several factors, the chief one being the constant lag in public provision for mental patients, with the resultant pressure for new institutions. This lag is a product of the constant changes of administration inherent in the practice of American state government, with its resulting irresponsibility of any one administration for long-time planning of mental health facilities. Each new administration is faced with an "emergency"; the easiest temporary solution of it is to build a new hospital.

Undoubtedly, too, the American penchant for size has influenced state authorities--if New York has a 5,000 bed hospital, Illinois must have one of 7,500 beds; each is then claimed to be "the last word" in planning and efficiency. And each promptly becomes filled with patients; each state has added one more large, expensive institution to be maintained, and the next administration faces a repetition of a similar "emergency."

An additional factor, operative at least until recently, has been the American habit of indulgence in smug self-satisfaction with its own devices, particularly with respect to European practices; they are to be dismissed without consideration because they are "European," and on the face of it impracticable in America. For this reason, large areas of valuable European experience have been excluded from consideration, let alone application to the already perfected American facilities of mass custody. Fortunately, signs of deflation of this unreasoning provincialism are appearing; for example, no major changes in the federal social welfare program would now be proposed for American adoption without careful study of similar services and their experience abroad. In no field is deflation more needed than in the care of the mentally ill; for the prevailing self-satisfaction can well be substituted careful examination of developments elsewhere and the possibilities of their profitable adaptation to the American scene.

In taking such a broader look, the first question which can be raised is, "How large should a state hospital be?" Exactly this question was raised in New York State in 1929 and well

deliberated;¹ the occasion was the contemplated action of the Department of Mental Hygiene of the State of New York to erect a 10,000 bed hospital (The Pilgrim State Hospital). The enormous size of such a single institution caused less bold minds to ask for thorough discussion of such an irrevocable move before its translation into concrete. Present at the discussion were legislators, representatives of state departments, hospital administrators, psychiatrists, and interested laymen from the states of New York and Massachusetts. The arguments for large and small hospitals were well presented; the result was inconclusive, and New York State proceeded with the construction of this large unit, whose capacity was immediately needed to relieve the overcrowding of an "emergency" situation.

In favor of the large institution, arguments were advanced of economy of construction, economy of physical operation, and economy of administrative direction. Of primary importance to the state of New York was that such a large number of beds would be made available quickly to meet the imperious demands of the "emergency" situation. In answer to these points, it was shown that economies of physical operation and administrative direction claimed for the large hospital were no larger for a 5,000 bed hospital than for one half that size; that after a certain point had been reached (2,000 to 3,000 beds) increasing size presented as many disadvantages as advantages. The preponderance of opinion favored the small hospital of 2,500 beds or less. It was particularly significant that the states of Massachusetts and New Jersey had each set 2,000 beds as the maximum size for a single hospital.

The emphasis of the conference, however, was properly laid on the influence of the size of the institution on the recovery of the patient. Evidence here was also inconclusive, but with a definite leaning toward the advantages of the small hospital. This phase was well summed up by the Chairman, Mr. Homer Folks, in these words:

1. That for the longer, or continued treatment cases, as well as for the more acute ones, individualized medical and other

¹New York State Charities Aid Association, Committee on Mental Hygiene, Publication No. 190, 1929.

care remains necessary.

2. That conditions involving primarily problems of personal readjustment cannot be met by impersonal methods.

3. That in any institution there is a trend toward impersonal methods, which increases with the size of the institution.

4. That this trend is inherent in the nature of institutions and is inevitable and irremovable; and while it may be measurably held in check by an alert and vigorous medical director who has succeeded in selecting a like-minded staff, medical and other, yet on the least relaxation of vigilance and effort, it resumes its normal trend to tradition and impersonality.¹

For Illinois, these findings have direct application. In the past, the state's hospitals have certainly been far removed from the leadership of "an alert and vigorous director"; only two or three of the present nine hospitals are now so blessed. Nor for the immediate future is there hope of such direction, either by appointment or development. In view of these considerations, the state Department would do well to place a definite limit on the size of existing hospitals, holding their expansion to the lowest possible point, and planning for the future that no new hospital exceed an ultimate size of 2,000 beds.

Several additional reasons support such a policy. A primary one is the declining rate of increase of the general population; by or before 1980 the population of the United States (and of Illinois) will have reached a maximum point.² With a stable or declining number of persons in the state, fewer (or at least no more) hospitals should be required. Inasmuch as the life of a modern institution is at least fifty years, this population factor should have immediate recognition in all plans for future institutions.

The smaller unit, too, would provide more flexible administration in a system of state-wide services. They would allow for better classification of patients, and for variation and experimentation in programs not possible in the larger institution. The application of the developments in therapy of the past two

¹Ibid., p. 6.

²Natural Resources Committee, The Problems of a Changing Population, chap. 1, "The Trend of Population," p. 24 (Washington, 1938).

decades can well be carried out in smaller institutions which are more adaptable to a particular program. The coming years may be expected to produce further contributions to therapy; it is reasonable to expect, similarly, that their application can be better carried out in smaller hospitals, allowing a diversity of approach in different institutions, together with a closer control of program in each.

The final point concerns the desirability of decentralizing the few large state hospitals and substituting smaller hospitals to serve smaller areas of the state. The asylum of the past has been a place apart because of its physical distance from most of the communities which it serves, and the stigma of mental disease which has separated it from the local community. The mental hospital of today is viewed with less abhorrence and is having more frequent contacts with the local community. The hospital of tomorrow will be comparatively free from stigma, a center of positive therapy and rehabilitative effort. It is the logical center for mental health activities in the local community--examination and treatment as at present, but additionally it will promote preventive work through education, demonstration, out-patient clinics, and patient supervision in the community. As these extra-mural services become of increasing importance in its work, a smaller institutional patient load should result. Hence the need for more small hospitals, scattered through the state, as focal points of this state-wide mental health plan for care and prevention.

Increasing attention should be paid to the development of the various forms of extra-mural care--farm and town colonies, family care in both colonies and single family units, and therapy centers in urban communities. The potentialities of these services have been given little consideration in Illinois; they merit both study and application.

The colony as a device for patient care is not new; most states use some form of farm colony for the care of mentally deficient or stable psychotic patients. Generally the purpose of the colony is industrial rather than therapeutic; the institutional farm is an important economic adjunct to the hospital. The use of colonies for truly therapeutic and rehabilitative purposes has been limited to a few states, among which the state of

New York is outstanding in its system of colonies centering about the Rome State School. The number and diversification of these colony units permits a wide range of classification of patients; their small size and careful integration into their local communities provides a more natural "family" group and makes them useful stepping-stones to the patient's parole to his own home or to his parole and placement in the local community.

Family care of mental patients is an old and well-proved device. It has been in continuous and expanding use at the world famous colony of Gheel, in Belgium, since the sixth century; its use in Scotland goes back a full century; the extensive experience in Germany and France each have several decades of successful practice. Fortunately, Europe has no prerogative on this form of care; the State of Massachusetts has made continuous use of it since Samuel Gridley Howe so cogently presented its merits in the 1860's. However the dominance of institutional philosophy and practice has obscured its merits until recent years; the last decade has seen its rediscovery and extended application in America. The latest figures¹ show that there were 893 patients in family care in the United States at the end of 1937, a remarkable increase of 290 patients during the year; most of these patients were in the states of New York and Massachusetts. This considerable development, largely within the last decade, has firmly established the feasibility and advantages of this form of care for certain classes of patient. Family care has long been proposed and discussed for Illinois; provision for it has been incorporated into the law;² it has never been used because of Departmental timidity about its feasibility. It should have immediate application; the groundwork has been laid and the facilities are available; further delay in its application on the part of the Department is indefensible.

The development of therapy centers for mental patients in urban communities is a proposal of this study for which an interesting and strong case can be made. The therapy center is an expansion of the familiar and useful device of the sheltered work-

¹U. S. Bureau of the Census, Patients in All Hospitals for Mental Disease, 1937 (Release of March 10, 1939).

²Revised Statutes, 1937, c. 142, sec. 26.

shop. To it, in the same building, should be added facilities for group therapy,¹ occupational therapy, recreational and social therapy, and for the use of organizations of recovered patients.

The purpose of the therapy center would be to make available to patients in the larger local communities those facilities for non-medical therapy which are assuming their proper importance in the process of social rehabilitation of the patient. These services are now available to some degree in the hospitals; there is large need of expansion of them there, and of making them available to non-institutional patients; this would be the function of the therapy center. Its plant would provide for workshops for occupational therapy, large rooms and auditoriums for a variety of recreational activities and meetings; play fields and park space would also be desirable. The program for patients attending the therapy center would be prescribed by the psychiatrist; the center would of course work in close conjunction with the hospitals and clinics in its area. Two classes of patients would be served, those under treatment at out-patient clinics, for whom institutional treatment is not indicated, and patients on parole from the hospitals who are in need of continuing social therapy and supervision.

The therapeutic possibilities of such a center have already been successfully demonstrated by their operation in various cities; for mental patients they could also show economic savings by reducing the number of hospital commitments and shortening the period of hospital care. Hospital care is expensive; the present flagrant waste of it on patients for whom it is unnecessary and socially crippling is later discussed. While a therapy center as described would call for a capital investment for plant and a substantial operating expense for professional staff, it would have constant use and serve a large number of patients; the cost per patient would be small. While under its treatment the patient would of course be living at home so that the cost of his maintenance would be saved to the state. The resulting total cost

¹By group therapy is meant the practice of group psychotherapy, by means of group conferences, lectures, discussions, and reading. Such a method of therapy is now being effectively developed at the Psychiatric Institute under the direction of Dr. A.A. Low.

for his continuing care would certainly be less than in the institution.

The high cost of institutional care deserves mention at this point; it is a phase of the care of the mentally ill which has been accepted with far less concern than it deserves. During the recent years of depression and lowered costs of operation, managing officers of the state institutions and the Director of the Department have pointed to reduced per capita costs of care as evidence of careful business administration. Too often this claim has been crassly false. Where lowered per-capita costs of care have been achieved by the reduction of essential services--smaller staffs, overcrowded wards, and discontinuance of social therapies, therapy has suffered and the recovery rate lowered. The long run cost, in terms of additional days (and lifetimes) of hospitalization mounts to a staggering sum; in comparison with it the boasted savings by temporary "economies" appear pitifully small and stupid.

Nor is the true cost of institutional care always recognized or admitted. The figure usually quoted is the per capita cost of maintenance--the total cost of operation for the year divided by the average number of patients under care. Neglected or omitted are the capital costs of depreciation and interest on capital investment; when these overhead costs are added the true cost of care is sharply increased. This cost situation has been carefully studied in New York State¹ but has had little attention in Illinois. It is worthy of further examination.

For New York State, in 1931, Mr. Pollock found that the annual cost of care in the civil state hospitals was \$711 per patient, made up of a maintenance cost of \$421 and investment and administrative costs of \$290. For the United States his estimate was \$624 for the same year. On the same basis, Illinois figures for 1937 would show a total cost of care of about \$343 per patient, made up of a per capita disbursement of \$248 and overhead charges (interest on investment and depreciation) of \$95. These costs, while below the national average and much below those of the eastern states, speak plainly when the large numbers of

¹Horatio Pollock, "Economic Loss to New York State and the United States on Account of Mental Diseases, 1931," Mental Hygiene, XVI (April, 1932), 289.

parolable patients in the hospital is considered.

As indicated at several points in this study, life in a large hospital has inherent in it an inevitably institutionalizing effect. Mass buildings, mass procedures, mass response--these all steadily unfit the patient for return to a normal life in his family and community. As Mr. Folks' summary so succinctly presents, this insidious lethargizing effect can be combatted only by the constant efforts of an alert and competent staff. Illinois' hospitals, so prominently lacking in these qualities, consequently exert this institutionalizing pressure to a large degree. And the total cost of it, applied to 30,000 patients spending years of their lives in the hospitals, quickly mounts to astronomical sums. Elementary arithmetic will demonstrate the indisputable economy of any increase of annual expenditures for therapy which will keep patients from entering state hospitals, shorten their hospital stay, or prevent their return. The taxpayer, therefore, has the strongest cause to demand that the mental health services be made as professionally competent and efficient as is humanly possible. For it is he who pays through the nose for tolerating anything less than the best attainable services.

The economics of mental health care, then, are strongly in favor of the minimizing of institutional treatment wherever possible, and the substitution for it of out-patient care, family care, and supervision of the patient in the community. In some cases extra-mural care may be a substitute for hospital care; more often it will be a complement to it, using the hospital when other treatment methods have failed, and receiving back from the hospital patients who have improved but are showing no further response to hospital therapy, and continuing their treatment and supervision in the community.

The clinic is a flexible device; its largest expense is for staff. Clinics can therefore be quickly set up; the present nucleus in Illinois can be rapidly expanded to meet the widespread need. Granting the passage of the Wagner Bill or an equivalent in the near future, the Department would be in a position to benefit both by grants-in-aid for hospital construction, and for clinic extension and operation. With some interest and initiative on the Department's part it should not be difficult to plan

for a truly statewide system of clinics, providing at least one clinic in each city of 25,000 population. Special grants-in-aid might also be procurable for experimental community programs such as the proposed therapy centers, so that some pioneering and research work could be attempted in the promising area of social therapy.

The backbone of any extra-mural service is social work. Without it histories are one-sided, diagnosis is hampered, and social treatment is impossible. The hospitals can use much more social work than is available to them at present; clinic operation is futile without competent social work staff. The Department already has a good beginning of social work organization; it can and should be greatly expanded. This expansion will require better salaries than are now paid and opportunities for advancement which are now totally lacking. The economics of patient care is so overwhelmingly in favor of the use of extra-mural care at every possible point.¹ An immediate increase in the number of social workers is therefore imperatively indicated.

The examination of the commitment laws brought out the many hardships now involved in their operation; it also strongly indicated that marked changes of both laws and practice were necessary in order that the present day viewpoint and processes of therapy may supersede the older and cruder devices designed chiefly for the protection of the community against the lunatic.

The changes proposed are simple in both legislation and practice; they are closely approached by much of the current procedure. In place of the existing commitment laws it is proposed to substitute certification to the guardianship of the Department for the purpose of necessary examination and therapy. Certification would be accomplished by examination of the patient by two licensed physicians, followed by completion of the certification form and the transfer of the patient to the nearest hospital.²

¹With an annual per capita cost in Illinois hospitals of \$340 per patient, it would require only 5 patients on parole to pay the salary of one case worker for their supervision. As a usual case load for one worker is 50 patients, the economics of the situation is compellingly in favor of extra-mural care for all patients for whom it is suitable.

²Full acknowledgment is made to Dr. A. A. Low, of the Psychiatric Institute, for his suggestions on needed changes in

The certification form should contain several essential points. These are: (a) the statement that the physician has examined the patient within 5 days; (b) a specific statement of the findings upon which he recommends commitment; (c) a statement that the patient and his guardian have been informed of his right to appeal to the State Commitment Court before his removal to the hospital, and his right of hearing before the Court if desired; (d) the signature and address of the physician. The form should be completed in duplicate, one copy to accompany the patient to the hospital, the second to be sent to the State Commitment Court.

The proper completion of this simple certification form can be encouraged by education and, if necessary, by the penalty of withdrawing the privilege of certification from persistently careless physicians. Early failures should be used as opportunities for an educational process with the physician, acquainting him with the necessity of proper examination and statement of his findings. A proper statement is necessary for several reasons--for the protection of the patient against hasty and unwarranted commitment, for the protection of the physician against possible civil suits by the patient on the same grounds, and for the information of the hospital physicians as to the reasons for commitment. Failure on the part of the physician to respond to this educational process (which failures would be very small in number) would eventually subject the offending physician to the threat of withdrawal of his privilege of certification. As this would deprive him of his fees from this source the threat would probably be sufficient to produce conformity on his part. If it did not, the privilege could be withdrawn. The enforcing agency would be the State Commitment Court. Reinstatement of the privilege of certification would only be restored by the Court on petition by the offending physician, possibly coupled with a period of probation.

The State Commitment Court would be established by legislation as a special court with the general rank of a county court, but with statewide jurisdiction. It should be composed of a county judge, who would preside, a qualified psychiatrist, and a

commitment procedure. The general concept of the State Commitment Court is also his; the writer has worked out its details and functioning.

lay member. Sessions would be held at the call of the presiding judge. Within 10 days after the date of certification it should review all certifications of patients to state or private hospitals, and should have the power to hear any appeal from certification by a patient or his guardian before his admission to the hospital; at its discretion it might require an examination of the patient by the Court's psychiatrist, or it might hold a hearing for the examination of the patient. It would also have the power to examine any patient in any state or private hospital at any time after admission, either on the request of the patient, his guardian, or the court's own initiative. It might order the discharge of any patient, however, only after due notice of its intention to do so has been sent to the Director of the Department.

This revised procedure would have the following advantages over the existing process of court commitment: (a) It would eliminate the present delay, harshness, and stigma of the hearing by the county court, and the unfavorable contacts with the sheriff and other law enforcing officers; (b) it would preserve the feature of certification by physicians, which is the only desirable feature of the present commitment process; (c) it would require the physician carefully to examine the patient, and state specific reasons for his certification. This examination would safeguard the patient and the physician, and supply essential information to the hospital staff; (d) the State Commitment Court would afford all the legal protection to the patient which is now afforded by the County Court. It would, in fact, afford greater protection, because it would have the services of a competent psychiatrist to appraise the necessity of commitment. The provision for appeal and review would probably satisfy the constitutional guarantees of due process.

The State Commitment Court would have the clerical staff necessary promptly to review the large number of certificates received daily, and check them for any irregularities in form or procedure. When necessary these irregularities would be brought to the attention of the physician, as described, or in more serious cases to the attention of the Court for its information and action.

In Cook County the state Department would use the Psycho-

pathic Hospital as a clearing house, as is its present use. Here patients could be examined in the hospital or clinics, and admitted to the type of care which the examination indicates is needed. There would desirably be a choice of various forms of care--out-patient clinics, with the patient remaining in his own or a substitute home during treatment; of short-term, intensive treatment in the Psychopathic Hospital, of transfer to the state hospital for a longer period of treatment, or any combination of these facilities. Such use of the Psychopathic Hospital would of course require its operation by the state Department, and is an additional reason for its early transfer to it, as proposed.

Finally, there remains the vital matter of prevention. The lack of any interest or action in the area of prevention of mental illness is one of the largest gaps in the state program. The Department has accepted responsibility for treatment of mental illness in the state; it spends \$7,000,000 annually for this purpose. It is faced with steadily increasing patient populations in its hospitals, and with increasing expenditures for their care. In the face of such large expenditures for such a major public health service, simple logic and economics would demand that the state pay attention to preventive measures, that the constantly increasing load may be checked.

Preventive work necessarily has two phases. The first is that of widespread education of the public about mental health; the second is the provision of local clinics as centers for early examination and preventive work in the local communities. The necessity for large expansion of out-patient clinics was set out earlier; their value as diagnostic and therapeutic services was then stressed. These values cannot be separated from their value as a preventive service; in many cases they actually prevent the necessity and expense of institutional treatment. Continued expansion of institutional facilities by the Department without provision of local out-patient clinics is a flat denial of its public health responsibilities. The necessity for public clinical services for mental illness is recognized by the United States Public Health Service; their provision is standard practice in many other states and countries. Illinois can no longer afford to neglect this fundamental responsibility.

Broad measures of public education in mental health are

an equally basic part of any public health program. The need for mental health education is the greater because of widespread popular ignorance, superstition, and fear about mental disorder. Their natural resultant is the deep-lying stigma which postpones early examination, complicates treatment, and makes the social rehabilitation of the patient immensely more difficult. These attitudes, widely held, result in a greatly increased cost of hospitalization, borne by the state and the taxpayer. The state, having accepted the responsibility for the hospitalization, can no longer avoid responsibility for the education of the public, whose ignorance complicates the whole program. Continued provision for hospitalization, with continued neglect of prevention, can only result in a constantly mounting institutional population, to the burden of patient and taxpayer alike. If only for self defense, the state must undertake public preventive efforts without further delay.

The administration of the public services for the mentally ill in Illinois has been lacking in professional viewpoint and backward in leadership. Lacking professional outlook, it has attempted to draw some belated professional backbone from the medical schools, but the graft has gross weaknesses; lacking administrative leadership, it has monotonously continued a narrow policy of institutionalization, to the neglect of other important phases of a sound mental health program. This narrow program must inevitably defeat itself. The remedy lies in the substitution of a sound professional viewpoint and direction, a workable Department, and leadership toward a broad mental health program for the whole state.

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